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ABSTRACT

This report details characteristics of 50 family care programs that provide comprehensive, individualized services to families struggling with various problems, as well as services that allow parents and children to continue living together in supervised living arrangements for extended periods. Data were collected through in-depth telephone interviews with staff supplemented with site visits. The report, intended as a resource for practitioners and policymakers, describes family care programs' daily operations and the elements differentiating them from other social services. The report explores the origins of family care, those whom the program serves, types of living arrangements, lengths of stay, the services offered, and aftercare approaches, illustrating each discussion with examples and quotes from program staff. The report highlights program elements found to make family care programs effective, including comprehensive services, longer treatment timelines and aftercare procedures, priority given to children's safety, an accepting yet demanding treatment environment, staff quality, and active peer support among residents. Also noted are the significant challenges in evaluating the effectiveness of family care programs, and evidence of women's enhanced participation in education and employment, decreased homelessness, increased self-esteem, and decreased depression and stress. Highlighting evidence of the positive impact of family care on children involved in such programs, the report concludes with recommendations for enlarging the impact of family care. Five appendices include a description of the study's methodology, one-page program summaries for all the programs surveyed, and a selective annotated bibliography on family care and related issues. Contains approximately 50 references. (KB)

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HEALING THE WHOLE FAMILY

A Look at Family Care Programs

PS 027906

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their chances of developing healthy self-esteem, enjoying a good relationship with their parents, succeeding in school, and avoiding substance abuse and victimization in the future. Equally important, children have the opportunity to see their parents acknowledge their own vulnerabilities and begin to change. Program staff say that such an experience increases older children's respect for the parent and can be a powerful motivator when they themselves encounter difficulties in their own lives.

- **Family care protects children's safety**.

Many programs for women with substance abuse problems require participants to complete 30 days of treatment before their children in foster care may become program residents. This period gives the woman time to adjust to the program and the staff time to make sure the client is committed to following through.

In all the family care programs, once a woman's child or children are on site, program staff closely monitor the mother–child relationship, with the intense and constant interaction among parents, children, and staff serving as a strong guarantor of children's safety. Most programs provide on-site, supervised child care for a substantial portion of each day, allowing trained staff to assess and monitor the children's development and overall well-being. In addition, because several families live together in one residence, other parents are available to provide respite to a parent temporarily overwhelmed by personal difficulties or parenting responsibilities.

- **Family care encourages troubled parents (most often mothers) to get help and strengthens their motivation to remain in treatment and use related services**.

Many women avoid voluntarily seeking help for substance abuse and other problems out of fear that traditional treatment and service programs may require them to forfeit custody of their children, at least temporarily, to the state. These mothers feel they "have to make a choice between recovery and their kids," says a family care program director in Detroit. Yet separating women from their children distances them from one of the primary reasons they are struggling to change their lives. "Women who do not have their children with them are grieving," says another family care program director in Rutland, Vt., "and the grief impedes their progress." By allowing mothers to keep their children with them during treatment, family care removes an emotional barrier to treatment and daily provides clients with a powerful reminder of why they must succeed.

Early in its history, the substance abuse program we surveyed in Honolulu enrolled some women who had at least one infant with them, as well as some women without any of their children. Those who entered the program with a child were three times more likely to complete the program. The director of the program says, "Traditionally, treatment is a time [for women] to focus on themselves; people say children will be a distraction for them. But for us, the relationship with the child is a primary concern. Treatment becomes more complicated, but we think it is also a more powerful experience." As a mother begins to see herself as a more competent parent and begins to develop better relationships with her children, her overall self-esteem increases and that in turn boosts the likelihood of her success in other aspects of her treatment plan. At the same time, some clients know that if they fail to complete the program, they are likely to lose custody of their children, and that, too, serves as a powerful motivator for change.

- **Family care strengthens the parent–child relationship**.

Keeping children and parents together while offering services to both generations is a bold departure from traditional social services. Yet family care goes even further in breaking new ground by focusing on the family unit itself. Recognizing that most of their clients were not well-nurtured as children and therefore may have weak nurturing skills, family care programs devote considerable effort and resources to strengthening the bonds between parent and child. As a program director in Chicago says, "Many clients really do not know what a healthy relationship looks like. Nobody showed them how to parent. Family care is not rehabilitation; it is habilitation. It is starting all over."

Family care programs provide family counseling and parenting education, but even more important, the residential setting allows the staff to offer constant and consistent on-the-spot guidance. Staff can see the

ABOUT CDF

The mission of the Children's Defense Fund is to *Leave No Child Behind*® and to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start*, and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

CDF provides a strong, effective voice for *all* the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of poor and minority children and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick or into trouble, drop out of school, or suffer family breakdown.

CDF began in 1973 and is a private, nonprofit organization supported by foundations, corporations, grants and individual donations. We have never taken government funds.

CDF works to improve practices and policies that affect large numbers of children, rather than helping families on a case-by-case basis. Our staff includes specialists in health, child welfare, mental health, child development, family income, and youth violence. CDF gathers data and disseminates information on key issues affecting children. We assess how private and public sector policies, priorities, and practices impact the health and safety of children and the ability of parents to support and nurture their children, and work to increase positive supports for children and their families.

CDF educates hundreds of thousands of citizens annually about children's needs and responsible options for meeting those needs. We provide information, technical assistance, and support to networks of state and local child advocates, service providers, and public and private sector officials and leaders.

CDF is a national organization with roots and branches in all 50 states and communities across America. Although our main office is in Washington, D.C., we reach out to towns and cities across the country to monitor the effects of changes in national, state, and local policies and to help people and organizations concerned with what happens to children. CDF maintains state, offices in California, Minnesota, New York, and Ohio, a Southern regional office of the Black Community Crusade for Children in Jackson, Miss., and local project offices in Marlboro County, S.C., and Columbus and Greater Cincinnati, Ohio. CDF has developed cooperative projects with groups in many states. CDF's Former Alex Haley Farm in Clinton, Tenn., serves as a school and spiritual renewal center for building a movement to *Leave No Child Behind*. The Black Community Crusade for Children, developed by Black leaders and coordinated by CDF, is an initiative to mobilize the African American community behind a targeted effort to address the special problems facing *every* child and family.

HEALING THE WHOLE FAMILY

A LOOK AT FAMILY CARE PROGRAMS

by MaryLee Allen and Jamila Larson

Children's Defense Fund

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We are especially grateful to the Hite Foundation for its generous support of our Family Care Research Project and its patience as the project grew and moved toward completion. We recognize and appreciate the foundation's strong commitment to safety and permanence for children and its continuing search for new ways to realize those goals.

During the course of our study, we learned so much from others who have studied and written about family care programs and other effective strategies for addressing the needs of families challenged by substance abuse, domestic violence, homelessness, and teen parenting. Amy Price at the National Abandoned Infants Assistance Resource Center, Laura Feig at the U.S. Department of Health and Human Services, and Gwen Rubenstein at the Legal Action Center provided special assistance.

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EXECUTIVE SUMMARY

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Healing the Whole Family: A Look at Family Care Programs describes 50 family care programs around the country surveyed by the Children's Defense Fund (CDF), with generous support from the Hite Foundation. CDF examined programs that treat or serve families struggling with substance abuse, homelessness, domestic violence, and teen parenting—problems that, if not addressed, all too often bring families to the door of the child welfare system. In this study, we defined family care programs as those that allow parents (usually mothers) and children to live together in supervised living arrangements for extended periods. These programs also provide comprehensive, individualized services to both the parent and child; as well as services to strengthen the family unit and promote family and economic stability.

CDF sees family care as an important component of the service continuum for some families for which in-home services will not work because the family is homeless, the children's or the mother's safety is at risk in the home, or for other reasons. Family care is appropriate when children's safety can be assured and when parents are committed both to complying with appropriate treatment regimens and to working hard to strengthen their families. The emphasis in family care on healing the whole family can offer family members a powerful opportunity to change their lives. This report describes how family care programs work on a daily basis and the core elements that make them different from other more traditional treatment programs and other social services. It also discusses their funding sources and the results of early efforts to assess family care's effectiveness. Finally, this report reviews the lessons learned from family care that can be used to help strengthen other services for children and families.

Healing the Whole Family is intended as a resource for child and family advocates, staff of public and private child and family service agencies, homeless shelters, domestic violence, teen parent, and substance abuse treatment programs, as well as legislators and other policy makers who are committed to finding better ways to keep children safe and in permanent families. The report is also relevant to the work of welfare agencies and employment and training agencies, since the problems addressed by family care programs are often the same ones that create serious barriers to employment for a portion of the people they serve. Treating families' problems and helping parents stay on the employment track can keep families moving toward economic and social stability and prevent them from needing to seek help from the child welfare system.

What Family Care Looks Like

Our survey of family care programs was designed to help us learn more about how family care programs are being used for families with different needs, in different settings, in different parts of the country. We were not necessarily looking for model programs, nor did we have the capacity to evaluate the programs we surveyed. In *Healing the Whole Family*, we explore the origins of family care, those whom it serves, types of living arrangements, lengths of stay, the services offered, and aftercare approaches, illustrating each discussion with rich examples and quotes from program staff.

We show how family care uniquely addresses a woman's needs as a woman (providing substance abuse treatment, health services, and therapy for sexual abuse, for example), as a mother (offering opportunities for parenting education, counseling, and role modeling), and as a community member (offering help with education, job training and employment, and opportunities to participate in community activities). We also describe the equally important services for the children, such as therapeutic child care, health services, and supervised "children of survivors" groups. Finally, we discuss what makes family care particularly unique—the attention paid to the family unit itself. Forty-three of the 50 programs we surveyed assess the parent–child relationship at intake, and many programs provide opportunities for supervised parent–child interaction, parenting education, family therapy, and organized family recreation. The report features brief profiles of five programs serving families with different primary needs. An appendix includes one-page summaries of all 50 programs surveyed and a grid showing the key characteristics of each program arranged by the target group of families served.

What Makes Family Care Effective

As part of our survey, we asked family care staff what makes their programs effective. We used their responses, along with our own analysis and that of other experts, to identify those elements that make the best family care programs work for the children and families they serve.

The elements that make them effective include:

- Comprehensive services that address the complex needs of parents, children, and the family unit.
- Longer treatment timelines and aftercare that allow genuine change and healing to take place, as families uncover and address problems for the first time, practice new behaviors in a supportive setting, and ease back into the community.
- Priority attention to children's safety.
- An accepting yet demanding treatment environment characterized by clear expectations and standards, as well as an understanding that relapses and setbacks are part of recovery.
- Committed, skillful, and flexible staff members who are able to address diverse and emerging needs.
- Active peer support among residents while in the program and as they make the transition back into the community.

How Family Care Is Supported

Two-thirds of the family care programs we surveyed had annual budgets of more than $600,000. Three-quarters of the programs in our survey depended on public resources for at least 80 percent of their annual budgets in the year they were surveyed. We examined the patchwork of federal, state, and local funding sources and other resources that help support these programs, which total at least 66 sources. Most of the family care programs we surveyed also depend on donations of time, expertise, gifts, and supplies from individuals and institutions in their communities. One program estimates that it receives more than $150,000 worth of volunteer services each year. Other programs identified specialized services they were able to provide only with donated help. The report lists the funding sources used by the family care programs, as well as their major sources of in-kind contributions.

How Family Care Differs from Traditional Child Welfare Services

Family care programs and local child welfare agencies tend to serve families with the same characteristics and histories. Unfortunately, the services typically offered by child welfare agencies too often do not get to the heart of a troubled family's complex needs. Sometimes a child is temporarily removed from the parent, but the parent may be left without help to solve the problems that had necessitated the child's removal. Even when services are provided to the parent, they may be incomplete and uncoordinated—short-term detox, for example, with no follow-up. As a result, children may return home but subsequently cycle in and out of foster homes or relatives' homes, as family crises erupt and subside. In fact, many parents participating in family care with one child have other children who had been placed in foster care earlier. The report explores the variety of relationships that exist between family care programs and child welfare agencies.

We at CDF believe there would be tremendous benefit to children, families, and the larger society if child welfare agencies and other agencies and programs serving vulnerable families were able to target services and treatment to both children and parents, strengthen parenting capacities and skills, and offer families follow-through services and aftercare. We believe that child welfare agencies, working together with programs offering substance abuse treatment and help to teen parents and parents struggling with homelessness and domestic violence, should find ways to offer family care when it is appropriate. At the very least, we encourage child welfare agencies to begin modifying their service approaches to incorporate some of the characteristics that have made family care effective in strengthening and stabilizing families and keeping children safely with their parents.

What We Know About the Success of Family Care

There is little doubt in the minds of those most closely involved with family care—program staff and families—that it improves many participants' lives. Many of the features of family care were added specifically to make the programs more responsive to the needs of women and children than other service and treatment approaches. However, the challenges in evaluating these types of programs are significant. Formal systematic evaluations of family care are still evolving, so current data on outcomes are limited. Several major reviews of family care programs are expected before the end of 1999, and other evaluations are underway.

Nonetheless, what we do know about the effectiveness of family care is encouraging. The best family care programs seem to be documenting success in alleviating harmful behaviors among the women they serve, such as alcohol and other drug abuse, repeat pregnancies among young teens, engagement in violent relationships, and involvement with the criminal justice system. There is also scattered evidence of enhanced participation in education and employment and of decreased homelessness. Early studies also show that women participants exhibit increases in self-esteem and decreases in depression and stress levels.

Outcome data for children are even scarcer, but programs are getting better at tracking these outcomes, too. Programs have found that babies born in family care are healthier; developmental scores improve for preschool children during residence; and there seems to be a positive impact on school performance for school-age children. Programs with strong parenting components also have found that parenting attitudes improve, parent–child attachment increases, and reunification of parents with children in foster care typically occurs.

What Challenges and Opportunities Lie Ahead

Despite its promise, serious challenges lie ahead for family care. Ongoing sources of funding are threatened by the move to managed care, some of the changes in the 1996 welfare law, and the termination of federal support for residential treatment programs for women with substance abuse problems and their children over the next several years. Yet other recent developments have the potential to increase states' interest in using the family care approach in dealing with vulnerable children and families. For example, to meet federally mandated performance rates for moving welfare recipients into the work force, states will be looking for ways to address such problems as substance abuse, domestic violence, and homelessness, which prevent parents from getting and keeping jobs to support their families. In addition, recent changes in child protection and adoption laws that expedite timelines for decision-making will make it essential that child welfare agencies get services and treatment to families as soon as they enter care. In both of these areas, the lessons of family care can be instructive. *Healing the Whole Family* offers recommendations for enlarging the impact of family care. Specific recommendations address the need for:

- Advocates for children to make a stronger case for investments in these troubled families.
- Expanded funding options for family care programs.
- Continued and expanded efforts to evaluate the impact of family care programs on children and parents and on the parent–child relationship.
- Enhanced capacity of child welfare agencies—through new partnerships with other agencies, programs, and community institutions—to address the needs of parents with substance abuse and domestic violence problems and those facing homelessness and teen parenting, in order to equip these parents with the skills and resources to build stable families for their children.

INTRODUCTION

In 1995, with generous support from the Hite Foundation, the Children's Defense Fund (CDF) undertook a study to determine the value of family care as an approach for serving families struggling with substance abuse, domestic violence, homelessness, and the vulnerabilities associated with teen parenting. Instead of separating children from their parents in times of family crisis, family care programs house children and parents together, simultaneously offering help to heal both generations at once. The goal of family care is to help break the intergenerational cycle of dysfunction that threatens, for decades to come, to condemn unacceptably large numbers of children to unstable homes.

From our study, we have concluded that family care offers a unique combination of services and activities that benefits children, families, and communities in ways not generally associated with traditional social services. In publishing this report, we are highlighting this model of care as a powerful tool for protecting children and stabilizing families, when the parents are willing to commit to change and work hard to strengthen their families so that their children can thrive.

For nearly two decades, CDF has worked to identify and promote efforts to make sure that all children grow up in stable, nurturing families, either with their parents, other family members, or adoptive families. CDF's landmark 1980 report, *Children Without Homes,* helped pave the way for important reforms on behalf of children who were first abused or neglected by their families, then neglected by the public agencies subsequently charged with their care. Since that time, our nation has taken important steps to protect its most vulnerable children. The Adoption Assistance and Child Welfare Act of 1980 helped reduce the practice of unnecessarily placing children in foster care when they could be cared for safely at home, and it helped ensure that children who must be placed in foster care would be placed in the most family-like setting consistent with their needs. This law also created new incentives for moving children into adoptive families or other permanent homes when it was not appropriate for them to return to their own families.

More recently, neighborhood-based family resource centers and home visiting programs for families with young children have expanded. They can help prevent child abuse and neglect by strengthening parents' ability to nurture their children appropriately. In 1993, establishment of the Family Preservation and Support Services Program (now called the Promoting Safe and Stable Families Program) provided a framework and resources to increase states' and communities' ability to offer these preventive services to strengthen families. For families already in crisis, the 1993 law increased resources for intensive services to avert future crises, protect children, and stabilize the family.

Despite these and other efforts, however, high rates of poverty among young families, drug and alcohol abuse, domestic violence, homelessness, and teen pregnancy have placed more and more children at risk of abuse and neglect. The number of community-based services available to heal troubled families and make it possible for children to remain safe at home does not begin to meet the need. As a result, our child welfare system has been stretched to the breaking point.

Operating in a constant crisis mode, child welfare agencies attempt to protect children in the short run by removing them from dangerous family situations. Yet their efforts generally do not address the long-term issues that underlie the immediate family crisis. Child welfare agencies seldom offer parents the intensive, comprehensive, and coordinated services that can prepare them to provide their children with safe, stable homes in the future. If these agencies do offer parents assistance, it tends to be short-term and narrowly focused detox, for example, or temporary safe shelter. When the immediate crisis has passed, the children often are reunited with their parents. But if the parents' underlying problems have not been addressed, the children are likely to cycle in and out of protective services and foster care, as periodic family crises erupt and subside. Other children live for years in foster care with no assurance of permanent families.

Enactment of the Adoption and Safe Families Act in November 1997 was intended to help promote permanent families for many of the 100,000 children who are waiting in foster care but cannot safely return to their own homes. The law's expedited timelines for achieving permanency for these and other children make it imperative that agencies provide increased services when children first enter foster care so that early decisions can be made about the likelihood of reunification. In addition, agencies and courts also need increased resources to make sure that children can be moved promptly to adoptive families, or other permanent settings, when reunification is not appropriate.

CDF, along with many other advocates for children, is convinced that our nation can, and must, do a better job of both keeping children safe and making it possible for them to live in permanent, stable, and nurturing families. CDF's Child Welfare and Mental Health Division has been committed to identifying and supporting more effective ways of addressing the needs of families most likely to end up in the child protection system.

To learn more about family care, CDF staff conducted extensive interviews with staff of 50 programs across the country that met our program criteria and seemed to provide strong and diverse examples of this model. We were interested in identifying a variety of family care programs at different stages of development, in different geographic areas, serving families with different primary needs, to get a clearer sense of what made them work and the challenges involved in operating them. We did not limit our survey to model programs, nor did we attempt to evaluate the programs we surveyed. Yet, since we were especially interested in comprehensive models—and programs that identify themselves as serving families dealing with substance abuse tend to offer the broadest range of services—we included more substance abuse programs in our survey than programs serving other target groups.

Obviously we could not include in our survey every family care program we initially identified. During our study we also learned about more wonderful programs that are working to heal whole families.

Family care is not appropriate for, or needed by, all troubled families, nor is it a panacea even for families for whom it seems appropriate. However, family care does offer many parents the best opportunity they may have to start building stable, productive lives for themselves and their children. Among the most important benefits of family care, we found the following:

- **Family care addresses the intergenerational cycle of family dysfunction that threatens the futures of many children**.

Children learn what they live, and family care is unique in introducing parents and children to a new way of life. Through the experience of living in a nurturing, home-like setting, families discover what it means to live in an environment where each individual receives emotional support and help to work through problems in a constructive manner. On a daily basis, program staff are able to model positive ways of coping and relating to others that children and parents can observe and incorporate into their own lives.

Family care also provides children with therapeutic child care and other prevention services that improve interactions between parent and child and commend them if they are positive and suggest another way if they are negative. Clients who were never hugged or praised as children learn how to hug and praise their own children by watching the staff do it. Clients who have always equated child discipline with slapping and spanking learn and practice other methods that are more respectful and more effective.

- **Family care helps prepare parents for living independently**.

Family care requires parents to participate fully in their own treatment plan while caring for their children, coping with everyday family problems, and meeting other demands of daily life. Clients are responsible, for example, for getting their children dressed, fed, and off to child care each morning, and for feeding, bathing, and putting them to bed each night. In many programs, clients also are expected to help plan meals, shop, cook, and perform other chores for the family care household, and balancing them with school or work, as well as to take care of their own family business: scheduling medical appointments, applying for social services, and looking for permanent housing.

Handling these responsibilities is difficult for some women struggling to overcome addictions or recover from violence and for teen mothers. Yet family care staff note that caring for children and maintaining a household and balancing them with school or work are the very challenges their clients will face when they return to the community, so it makes sense to prepare them to meet these responsibilities. Clients are not expected to do all this without help, however. Family care offers mentoring, support from staff and peers, and classes that teach such practical skills as budgeting and time management.

Parents who complete a family care program not only have received help to overcome their personal difficulties, they also have typically strengthened their parenting and general life skills and made progress toward their educational or employment goals. When they return to their community, they are more likely than clients of traditional social services to have the basic tools they need to keep their own lives on track and raise their children to become productive citizens and caring and competent parents.

We believe it is even more urgent now to step up our efforts to heal the whole family than it was when we began our survey in late 1995. Both welfare and child welfare systems across the country are facing increased pressures to assist families challenged by substance abuse, domestic violence, homelessness, and teen parenting. Among families on the welfare rolls, these families generally face the greatest barriers to employment. Yet welfare staff will have to help the parents find and retain jobs if the states are to avoid penalties under the 1996 federal welfare law. If these families are not helped to find and retain jobs and are ultimately dropped from the welfare rolls when their eligibility expires, at least some of them are likely to end up at the door of the child welfare system. There also are new legislative mandates that are creating additional pressure on child welfare agencies to address families' needs quickly, so that timely decisions can be made about permanency plans for children.

Our survey of family care has convinced us that if more of these programs were available to serve troubled families and if more of the salient characteristics of family care were incorporated into the services and treatment offered by a broad range of systems, our nation would be more likely to one day *Leave No Child Behind*. We hope this report will result in more children, families, and communities having the chance to benefit from the opportunity family care offers.

Healing the Whole Family is organized into seven chapters. The first three describe what family care looks like and what makes it effective. Chapter 4 discusses important links between child welfare agencies and family care programs and the features of family care that can help stabilize and heal families in the child welfare system. Chapters 5 and 6 describe the patchwork approach to funding that characterizes the programs we studied and what we know to date about the success of family care programs. Chapter 7 includes recommendations for enhancing family care, expanding its reach, and incorporating its core elements into other services to ensure safety and permanence for children. The appendices include a brief discussion of the study methodology, an annotated bibliography on family care, descriptions of the family care programs included in our study, and lists of the various sources used in the report.

Chapter 1

WHAT FAMILY CARE PROGRAMS LOOK LIKE

In the Children's Defense Fund's (CDF) survey of family care programs, we were eager to find out how this promising model is being implemented in communities across America. Our interviews and follow-up with program staff sought in-depth information about the programs and what makes them work. We explored the similarities and differences between programs serving families struggling with substance abuse, domestic violence, homelessness, or teen parenting. In this chapter, we describe the origins of the programs, whom they serve, how long families stay, and their living arrangements.

How They Began

The origins of the 50 family care programs CDF surveyed were varied but all developed in response to specific unmet needs in the community. In many cases, a program was the brainchild of individuals who were frustrated by their community's lack of adequate resources to help a particular population of vulnerable families. For example, the **Bridgeway** program for pregnant and parenting teens in Lakewood, Colo., grew out of a citizen's distress upon reading local newspaper reports of teenage mothers leaving newborn babies in dumpsters. In Los Angeles, staff at Martin Luther King Hospital who were worried about the futures of the approximately 1,200 infants born drug exposed there each year pushed for creation of the SHIELDS substance abuse treatment program, out of which grew the **Exodus** family care program.

In several instances, family care programs were conceived by would-be clients seeking help for themselves as well as others. **Domestic Violence Intervention Services, Inc.**, in Tulsa, Okla., was started by two formerly battered women who were trying to give each other support. They started a crisis telephone line out of their homes, which eventually grew into an incorporated residential program.

Similarly, a group of women recovering from alcoholism who volunteered at an Alcoholics Anonymous (AA) chapter in Cincinnati began discussing how fortunate they felt: "We had education, economic security, and access to treatment," explains one woman, "and recovery was difficult. Just imagine what it would be like with no education or income, where you return to a drug-infested neighborhood. It must feel insurmountable!" These women discovered that no residential treatment for families was available in Cincinnati, and the treatment program for women without their children had a six-month waiting list. "All these people motivated for treatment and no place to go!" the woman recalls. In response, the women worked with the county and several community groups to develop a successful grant proposal for **First Step Home**.

Other family care programs were started by state and local governments or in response to government initiatives. The impetus for the creation of the **Crittenton Hastings House** in Boston was the state's new welfare law, which forbid pregnant teens from collecting benefits while living on their own. Pregnant teenagers unable to live with their parents because of abuse, family conflicts, abandonment, or overcrowded living conditions needed help to avoid falling into a downward spiral of homelessness, crime, abusive relationships, and an unhealthy pregnancy. **Crittenton Hastings House** not only provides such teens with a safe haven but offers the structure, teaching, and support to help them build healthy families.

Like the **Pregnant & Postpartum Women & Infants Program** in Chicago and the **Women & Children's Residential Program** in Fairbanks, Alaska, the majority of the 22 family care substance abuse programs we interviewed owed their existence, at least in part, to two federal funding initiatives in the early 1990s. The Demonstration Grant Program for Residential Treatment for Women and Their Children and the Services Grant Program for Residential Treatment for Pregnant and Postpartum Women both required a range of services to permit children to live with their mothers during treatment.

Many family care programs began as traditional homeless shelters or drug treatment programs, then evolved as they sought to do a better job of meeting their clients' needs. The Village in Miami initially offered substance abuse treatment for men, then added treatment for women, realizing they had different treatment needs. The staff discovered, however, that women left treatment sooner than men because they were worried about their children. The agency then developed a third program, **Families in Transition**, which allowed women to keep their children with them while they received treatment.

Casa Rita in New York started out as a homeless shelter, but because most of the women came in with substance abuse problems, the shelter turned itself into a family care substance abuse program to meet the clients' needs.

Family care programs for victims of domestic violence, many of which grew out of the women's movement, often trace their origins to crisis telephone lines. The director of **Middle Way House** in Bloomington, Ind., explains the program's evolution into a family care program this way: "The women and kids were literally at the door!"

Typically, family care for teen parents began in more traditional maternity homes for teenagers that required the mothers to leave after giving birth. **Teen Parenting Services** in Portland, Maine, grew from a day program for teen mothers. The staff realized that "success came undone at night." Another family care program was created when staff of the parent agency's shelter for runaway teens noticed that many of those seeking shelter were pregnant.

Family care programs for homeless families are likely to have begun simply as shelters that offered little more than food and a place to sleep. Yet shelter staff and advocates for the homeless realized that many homeless families were not able to turn their lives around within the few weeks they were allowed to live in the shelter. Traditional shelters often split up families instead of allowing them to stay together. Until the family care program, **YWCA Transitional Housing at NIA Terrace**, was established in Jacksonville, Fla., for example, homeless families had to separate because no shelters would accept fathers or children older than age 8.

Traditional shelters can even be dangerous places, particularly for children. In New York, enormous dilapidated "welfare hotels" and barrack-style shelters stored thousands of families in environments rife with drug use, prostitution, and even murder. Parents had difficulty protecting their children from the environment, let alone finding the support they needed to build a better life. Now the more fortunate homeless families who are able to enroll in programs in the city like **ABC–Rosie & Harry's Place** not only stay together and are safe, they also are getting the kind of help that prepares them to live safely and independently in the community.

The Families They Serve

Family care programs generally identify themselves as serving clients (most often mothers) with a particular problem—substance abuse, domestic violence, homelessness, or teen pregnancy and parenting. In reality, however, families in all of these programs are likely to share similar backgrounds and have similar needs, often facing all of the above and more. How they finally reach this level of care and which system catches them first varies considerably. Parents often have tried other treatment programs, are determined to need intensive residential services, and are committed to completing the program.

Families find their way to family care programs by many routes, word-of-mouth being one of the most common. Human service agencies, including child welfare, law enforcement, the courts, and emergency shelters, are equally common sources of referrals. Some programs run extensive outreach efforts, using billboards, newspaper ads, brochures, and public service announcements on the radio. In all of the programs we surveyed, clients enter voluntarily. In some cases, however, courts have offered the mother the option of enrolling in family care as an alternative to being incarcerated or losing custody of her children.

Family care programs typically serve women with few other options, but they do not accept everyone who applies. The programs we studied generally do not work with parents who are actively suicidal, psychotic, or have been convicted of sexual abuse or a weapons charge. Before being admitted into a family care program for the homeless, families typically must be screened through a city's shelter system. None of the family care programs we surveyed accepts persons currently abusing drugs or alcohol. Even substance abuse programs require new clients to come in clean and sober, and many such clients enter family care after a period of inpatient hospital treatment.

The domestic violence programs we surveyed appear to impose the fewest admission requirements. Space permitting, they accept most families who are being threatened by a violent family member.

In an effort to reduce client turnover, family care staff say they work hard to make sure the women they admit to their programs understand the commitment involved. As the director of one family care program said, "This is going to change their lives and it's long term; we only need people who are willing to try." According to staff, **Teen Parenting Services** in Portland, Maine, significantly reduced turnover when the program stopped taking clients on a first-come, first-served basis and started screening potential participants. The staff ask current clients to help with the screening, having discovered that they are good judges of their peers' willingness and ability to commit to the program.

We found that all of the programs for homeless families that we contacted accept mothers and fathers, although the overwhelming majority of the families in residence are headed by women. At **Harmony House** in Newark, N.J., for example, about 10 percent of the families are headed by two parents, 5 percent by single fathers, and the remainder by single mothers. A few programs, like **Warren Village** in Denver, accept only single parents.

In our survey, **Teen Parenting Services** was the only family care program for teenage parents that accepts teen fathers and mothers together. If the father—or another partner—is committed to the family and wants to parent, he should receive the necessary support and guidance, says the director, noting that young fathers get mixed messages in our culture. "They are blamed for impregnating a girl and leaving, yet families are penalized [by welfare rules, for example] for having males around. And young fathers aren't offered the opportunity to learn how to be a dad and a partner." Half of the families participating in **Teen Parenting Services** are headed by two parents, and a few are headed by single fathers.

Some programs target teens within their broader client population. **Rainbow House** in Chicago, for example, serves teenage victims of domestic violence, half of whom are parents or are pregnant. The program developed out of a recognition that battered teenagers are falling through the cracks, too young to be accepted into domestic violence shelters, and too old and too needy for traditional group homes. Says the director, "We thought the younger we interrupt the cycle, the better." Similarly, **Project BASTA** in Boston serves teens who are homeless and have been victims of domestic violence; they also may have family histories of substance abuse. (See box below.)

Family care programs vary in the ages and number

Project BASTA

"Addressing domestic violence, substance abuse, homelessness, and teenage pregnancy . . . all under one roof."

Just before giving premature birth to "Michael," who weighed one and one-half pounds, "Sonja" entered Project BASTA in Boston. Sonja was not a drug user, but her mother had died when Sonja was very young, her father suffered from mental illness and alcoholism, and she had witnessed a tremendous amount of violence as a child. When her stepmother became physically abusive toward her, 20-year-old Sonja sought emergency shelter at Casa Myrna Vasquez, which has been serving battered women and their children in the Boston area for more than two decades.

After three months, staff there referred Sonja to Project BASTA, a residential program that Casa Myrna Vasquez created in 1992 to offer adolescent victims of domestic violence and their children comprehensive services, including substance abuse prevention, treatment, and recovery services. The agency had received a grant from the federal Center for Substance Abuse Prevention, after finding that an increasing number of its clients were teenagers with substance abuse problems who were not being adequately served in traditional shelters for battered women.

Project BASTA serves 16 mothers (eight of whom are teenagers) and their children, during average stays of about 14 months. Staff say their first concern when a young woman such as Sonja enters the program is to help her feel safe, so that the healing process can begin. On entry, the teens are given both mental health and legal assessments and are referred to prenatal and other health care services immediately. Then, through daily structured activities, the young mothers gain the tools they need to change their lives and give their children the healthy upbringing they never had.

Project BASTA staff say that from the beginning, Sonja participated fully in the program. She responded well to her work with a staff therapist and attended all the required meetings and groups, including a clinical support group, psycho-educational workshops on domestic violence, house meetings, and substance abuse prevention workshops. All of the young women attend substance abuse prevention workshops because their circumstances put them at high risk for future use.

Unlike many of her peers in the program, Sonja came to Project BASTA to flee an abusive stepparent rather than an abusive husband or boyfriend. Teens generally come to the program with multiple levels of abuse "from their siblings, uncles, boyfriends, and parents," says the director. "The violence from the boyfriend brings them in. It's the violence from the family of origin that we discover later. They say, 'Oh no, [my boyfriend's] not my batterer, we just fight.' They are not able to identify abuse or take it seriously."

Sonja, who had earlier attended a local community college, planned to find employment after giving birth. However, she found that during her first months in the program she had to focus much of her attention on Michael, who spent his first month of life in a neonatal intensive care unit. Sonja's case of children they serve. In some programs, the number of children each mother is allowed to have with her depends on how many can share a single bedroom. In other programs, funding and other constraints determine the number of children who can be served. At **Casa Rita**, for example, the New York fire code limits to four the number of children in each bedroom. At **Women's Way** in Honolulu, a program for women recovering from

manager at Project BASTA realized that he would likely be eligible for Supplemental Security Income (SSI) disability benefits and helped Sonja apply right away. Staff also helped Sonja find an early childhood intervention program in the community, and the family soon began receiving weekly visits from a specialist there who taught Sonja how to care for such a small and medically fragile baby.

At Casa Myrna Vasquez, as in many family care programs, children's needs have been getting more attention in recent years. The agency has just received a grant to double its children's services staff, which will enable Project BASTA to buttress its on-site child care program with more prevention services for newborns and more therapeutic services for the older children whose lives already have been marked by violence. When a child's needs go beyond the expertise of staff, the child is referred to a pediatric unit at Boston City Hospital that specializes in treating children who have witnessed violence.

Casa Myrna Vasquez is committed to close collaboration with other city agencies and has advocated for battered women to receive the same benefits as other homeless persons. The medical needs of its families, including home visits, are now taken care of by Health Care for the Homeless, and a staff member in the public school's homeless unit helps coordinate school changes for its children.

Staff members acknowledge that serving teenagers with such traumatic backgrounds is not easy. "The developmental issues of the teens make it very difficult for them to abide by the rules," says the director. Yet Project BASTA manages to make a positive difference in the lives of the young women it serves. The program reports that 95 percent of its participants who made it to graduation either reduced their use of alcohol, maintained sobriety, or did not begin to drink; 100 percent reported a reduction or elimination of physical abuse; and 94 percent received postpartum health care. At a two-year follow-up, 88 percent of the young women continued to report a reduction in physical abuse.

About eight months after entering the program, Sonja was informed that her application for subsidized housing had been accepted, and she began looking for an apartment. She also started filling out applications for nursing school.

It took two months, but Sonja finally moved into her own apartment, furnished with donations from local charities. Project BASTA staff put her in touch with an early intervention program in her new neighborhood so that Michael could continue to progress. Sonja also checked in regularly with Project BASTA staff and attended weekly support groups. After two years, she is in the same apartment, has completed a one-year nursing program, and is looking for a full-time job. She has a nonabusive boyfriend and has had no abusive relationships. Michael is in child care and is developing well.

Sonja says that Project BASTA helped her learn how to be strong, how to say no, and how to choose the right kind of friends. The most important part of the program for her, she says, was her relationships with the staff.

Although not all of Project BASTA's participants are able to take control of their lives as quickly and completely as Sonja, the staff work tirelessly to help them succeed, step-by-step. "Embracing the whole [of the young women's experiences]," says the director, "that's our strength and greatest challenge."

substance abuse, the reimbursement rate covers only one child per parent, so taking in additional children would displace parents.

If clients have children other than those living with them in family care, they are likely to be with relatives or in foster care. Many of the programs we surveyed work to support the mothers' relationships with their absent children by offering visiting opportunities, weekend stays, and, in some cases, access to their on-site services and activities. At **A New Life** in Philadelphia, for example, relative caretakers and foster parents for children whose mothers are in substance abuse treatment are encouraged to enroll the children in **A New Life's** child care services or in the after-school program and summer camp at the community center where the treatment program is located. In Cincinnati, children ages 6 to 11 who cannot be accommodated with their mothers at **First Step Home** are cared for by GLAD House, a therapeutic group home begun by a local church. The group home facilitates contact between the children and their mothers in treatment for substance abuse and welcomes the children back for services after they are reunited with their mothers.

Our survey suggests that the strictest age limits on children in residence are imposed by substance abuse programs, where children often have to be younger than age 10 or 13. Programs for homeless families seem to have the fewest restrictions on age and family composition. **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., for example, allows anyone the client considers part of her family to live with her in her private apartment unit. Domestic violence programs generally allow older females to be admitted but do not accept males older than age 13 or 15.

Family care programs often do not accept teenage males, partly because they are perceived as posing a potential threat to other clients and their children, particularly if they are modeling abusive behavior. Yet programs that do accept male teenagers take them in for that very reason, arguing that it is important to intercede early to prevent them from growing up to be abusers. Staff at **HerStory House**, a domestic violence program in Rutland, Vt., say they notice that the males older than age 10 almost always identify with and follow the father, unless they too are being battered. The few males who do come to **HerStory House** share a bedroom separated from the rest of the house.

Many of the staff we interviewed report that their programs are unable to offer adequate specialized treatment and age-appropriate activities for teenagers, regardless of gender. They say that the resources and staff expertise to develop specialized services are scarce and the physical limitations of their facilities make it difficult to provide the privacy that teens need.

Length of Stay

The longer length of stay typical of family care programs sets them apart from other services for similar target groups. Families come into treatment with different needs, and family care programs offer the flexibility to best address those needs. Longer treatment timelines make possible the type of healing that needs to take place. Staff at **Greentree Shelter** for homeless families in Bethesda, Md., say, "The families are here long enough to do some real work!"

Programs often have general treatment timetables, and clients are expected to make progress in their treatment plans. Yet the length of time it takes to complete a particular family care program may vary from family to family, depending on how quickly each family is progressing and how well the program meets each family's needs. A family's departure date is usually a joint decision of the program staff and the client, consistent of course with funding limitations. Family care programs' commitment to try to make sure clients are ready for the next step when they leave is illustrated by this comment from a **Hutchinson Place** staff member, a program in Philadelphia serving families struggling with substance abuse: "We do not let them leave here," she says, "until they have somewhere to go and have enough space for all their kids to live there."

Our survey suggests that the length of stay tends to be shortest in domestic violence programs, where it ranges from two weeks (with the expectation that families will then move into on-site transitional housing) to three months. In substance abuse programs, the length of stay ranges from three months to 18 months, and in programs for pregnant and parenting teenagers, the range is from eight months to two years. Among the surveyed programs for homeless families, the shortest stay was six months, and the longest was eight years, accounting for the fact that some of the programs provided long-term transitional housing.

A major challenge in family care is retaining families beyond the first 30 days when the transition is the most difficult. In addition to better screening, programs emphasize the need to intensify services up front to discourage the women from returning to dangerous or unhealthy environments.

The staff of many programs report that the length of treatment is a pivotal factor in a family's ability to build a stable life after leaving the program. Like many substance abuse programs, **Women's Residential Services** in Libertyville, Ill., has found that at least six months of residential treatment is necessary for most clients to benefit fully. A drop in that program's funding, however, has dictated that the treatment period be halved. Although the director acknowledged that it had forced them to work smarter, but as a result of the shortened time limit, the women have less sobriety and have received fewer services by the time they must leave the program.

An evaluation of the formerly homeless families at **ABC–Rosie & Harry's Place** in New York between November 1993 and July 1997 found that families who successfully completed the program had significantly longer lengths of stays than other families.

Families in Transition, a substance abuse program in Miami, reports that as the length of stay increases, drug use at follow-up decreases. Although 84 percent of the women who dropped out of the program within six months were using drugs six months later, just 16 percent of those who remained in the program for six months or longer were using drugs after being on their own for six months.

Although a 1996 study of the 38 grant programs for Residential Treatment for Women and Children funded by the Center for Substance Abuse Treatment revealed that only 30 percent of the women completed the treatment successfully, efforts to better target clients appropriately and to implement more comprehensive programming is pushing up that average considerably in some of the programs studied. Some programs like **Integrated Family Treatment Center** in San Antonio estimate about half of their clients successfully complete the program. **Exodus** in Compton, Calif., which treats clients with long histories of alcohol and other drug abuse, reports a 65 percent success rate. **Casa Rita** in New York estimates 75 percent of the families are successful.

It is not unusual for clients to leave a program prematurely, then ask to return to complete the program. A staff member at **Teen Parenting Services** in Portland, Maine, expresses the attitude of many programs we interviewed on this issue: "If they have an interest in trying again, we'll stick with them."

Living Arrangements

The number of families accommodated at one time in family care programs varies according to the target group each program serves. Among the programs we surveyed, those for women victimized by domestic violence are typically the smallest, accommodating on average six to eight families at a time; however one program serves up to 25 families at once. Programs for pregnant and parenting teens serve an average of 15 families simultaneously, with the range extending from four to 18 families. The capacity of most of the substance abuse programs we surveyed is between 10 and 20 families, but the largest can accommodate 50 families. Programs for homeless families typically serve 50 to 60 families at a time, with the smallest serving 12 families, and the largest, Homes for the Homeless in New York, serving up to 200 at **Saratoga Family Inn**.

Family care programs house their families in a variety of living arrangements. They range from mentor homes, in which the family lives with another family in the community (see box on page 8), to large houses in which several families live together in a supportive setting, to apartments where families live independently.

The vast majority of programs for parents who are teens, victims of domestic violence, or recovering from substance abuse operate group houses. Each family typically has one bedroom and shares the bathroom,

Shared Family Care

Some family care programs, including two featured in this report, rely on a type of care —now called Shared Family Care—that can be traced back to the Middle Ages and is used in Sweden and other European countries as an alternative to institutionalizing individuals who need special care. In the United States, it has sometimes been used for aging adults and adults with mental health problems. Recently, some social service providers have begun to use Shared Family Care to help high-need families function better and become self-sufficient.

In Shared Family Care, the entire family is temporarily placed in the home of a host family whose members are trained to mentor the parents as they develop the various skills and supports necessary to live independently with their children. Among the family care programs we surveyed, **Therapeutic Foster Families** for teen parents in Chicago and **A New Life** for families recovering from substance abuse in Philadelphia use this model. The state of Colorado is interested in expanding its use of Shared Family Care, and there also are Shared Family Care projects in California, Minnesota, and New Jersey. Like family care generally, Shared Family Care is not appropriate or effective for all families, but it can be one important option in a continuum of services available in a community.

In Shared Family Care, client families are carefully matched with host families who can help them progress toward independence. Called mentors, foster families, resource parents, or care providers, these host families must be nonjudgmental, fully committed to helping families with multiple problems, and willing to function as part of a treatment team. Generally, mentors live in or nearby the communities in which the families to be served reside.

Like other types of family care programs, the mission of Shared Family Care is to protect children by offering services to both parents and children in a safe and supportive setting. Parents not only receive emotional support and nurturing from mentors, but also receive practical help and guidance in parenting their children, establishing healthy routines, solving day-to-day problems, coping with stress, and forging connections with community resources. The mentors serve as models for the parents as they work to develop and practice new parenting and life skills.

Mentors also assume specific tasks as part of the treatment team and are responsible for documenting and reporting on daily experiences. Ongoing training and support of mentors are essential to the effectiveness of Shared Family Care. Mentors generally participate in peer groups in which they can talk, apart from the families and formal treatment providers, about the challenges involved in taking high-need families into their homes. Respite care is especially important for mentors, who are on call continually, except when parents and children attend treatment and participate in other services. Generally mentors are compensated for their services and for the cost of the families' room and board.

Often relationships between mentors and the families they serve continue after the families move into permanent housing. It is not unusual for mentors to keep in touch by phone, provide occasional child care, and invite the families back for holiday celebrations.

The National Abandoned Infants Assistance (AIA) Resource Center at the School of Social Welfare at the University of California at Berkeley has played an important role in highlighting the benefits of Shared Family Care. The Resource Center has developed "Shared Family Care Program Guidelines," which provide information that can be customized by organizations interested in starting Shared Family Care. The center also is evaluating demonstration projects in California and Colorado and has developed a mentor training curriculum outline and resource manual. For further information, contact the AIA Resource Center at 510-643-8383.

kitchen, dining room, living room, and laundry facilities with others in the home. This arrangement creates a family-like community, a critical ingredient in the family care treatment approach and a reason the programs often prefer to be small. Smaller programs not only allow clients to experience what it means to live in a supportive family, but they also offer clients more opportunity for individual attention and closer relationships with staff.

All but one of the surveyed programs for homeless families and a few of each of the other types of programs house families separately in self-contained apartments. This arrangement encourages more autonomy than a group house allows and gives residents a greater taste of self-sufficiency. In addition, some programs for substance abuse, domestic violence, and teen parents offer clients a period of transitional apartment living before they strike out on their own (see pages 32–33). A few programs, such as **Exodus** in Compton, Calif., own an apartment building. In other programs, family care apartments are interspersed among others in a large complex. **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., for example, owns 47 units in a new complex of 237 apartments.

Some programs own a cluster of separate houses or small apartment buildings, with child care and other services provided in the same complex. The **Crittenton Programs, Inc.**, for pregnant teens in Wheeling, W.Va., has four houses to accommodate young women at different stages in the program. One house is a maternity home for clients who are newly admitted, staffed by a nurse 24 hours a day. Another house, for mothers and newborns, is staffed by an infant care specialist, to help with everything from baths to night feedings. The remaining two houses are for mothers and their toddlers, as the families become more self-sufficient.

Although a few family care programs, such as the domestic violence program, **Family Sunshine Center** in Montgomery, Ala., have been able to build facilities specifically to meet their needs, most have had to be creative with what they have. In some cases, programs were given a building by an individual or organization; some inherited one owned by the parent agency. Most often, family care programs have bought a building left behind by another agency.

Casa Rita in New York, for example, is housed in an old school. The **Pregnant & Postpartum Women & Infants Program** in Chicago operates in a former hospital. Cincinnati's **First Step Home** is located in a former rectory. **Integrated Family Treatment Program** in San Antonio uses the cottages on the grounds of a former residence for children with emotional problems. **Women's Residential Services** in Libertyville, Ill., is located above a nursing home.

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Chapter 2

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SERVICES OFFERED BY FAMILY CARE PROGRAMS

The family care programs we surveyed typically offer a comprehensive menu of services designed to address the individual needs of parents and children and improve family functioning, in addition to providing the basics of food and shelter. In Appendix D, we include a service summary for each program. Here, we group the services into four general categories and describe each in more detail later in this chapter: services for the client as a woman (providing substance abuse treatment, health services, and therapy for sexual abuse, for example), services for the client as a mother (offering opportunities for parenting education, counseling, and role modeling), services for the client as a community member (offering help with education, job training, and employment, and opportunities to participate in community activities), and services for the clients' children (such as therapeutic child care, health services, and supervised "children of survivors" groups). We generally use female references throughout the report because the vast majority of family care programs we surveyed served mothers, although, as you will learn, there were some notable exceptions.

We begin the chapter with an overview of the early weeks of residence in family care when the women are becoming acclimated to their new environment, and some general characteristics of family care services.

Overview

When women first enter family care, they are typically in crisis. Some have just left a violent partner; others have just finished a detox program—sometimes after repeated previous attempts at sobriety. If they are pregnant teens, angry parents may have forced them to leave home. Some women who enter family care find themselves separated from their families and everything that is familiar to them for the first time in their lives.

During this period, the risk for dropping out is high. The director of **Seton Home** for pregnant teens in San Antonio says, "For most, this is the first time they've ever had structure in their lives, so the first month is pretty rocky. The testing [of staff] usually takes a month to settle." Because the first weeks are so new and challenging, the women at **Middle Way House** for victims of domestic violence in Bloomington, Ind., meet with a counselor every day.

For women who choose to stay, the first month is generally a time when their bodies have a chance to heal and their minds a chance to clear. Domestic violence programs report that their clients often need at least a month before they feel safe and believe they have enough control over their lives to plan for the future. A staff member at **Women's Residential Services** substance abuse program in Libertyville, Ill., says the women generally need the first month to become medically stable and regain the energy they will need to participate fully in the treatment program.

Some programs, such as Philadelphia's **A New Life** and **Hutchinson Place**, impose a 30-day black-out period, during which a new resident is not allowed to associate with anyone outside the substance abuse program. The Evaluation Report for **Exodus** in Compton, Calif., notes that a new client's apartment key is held by the housing staff for the first two weeks to monitor her attendance at treatment and adherence to house rules. No passes to leave the housing complex are issued during the first 30 days of treatment. The goal is to encourage the woman to get used to relying on herself, the staff, and other residents, so she can fully submerge herself in treatment.

In most programs, a new client is assigned to a counselor to help her assess her needs and map out goals for herself and her family that will become central to her treatment. The parent agency of **Project BASTA**, a domestic violence program in Boston, provides lawyers to help the women assess their legal situation and needs.

The staff at **HerStory House** estimate that about 20 percent of the women who come to this domestic violence program in Rutland, Vt., are "stuck" when they enter family care, with little idea of what to do with their lives. "They are not stupid or slow, they just need more intense mini-goal-setting," says a staff member. "With such low self-esteem, how can they be sure they are making the right decisions?"

In the short term, a woman's goals might include taking her child to a doctor, getting a court order of protection against a violent spouse, or applying for emergency assistance benefits. Long-term goals might include continuing sobriety, using nonviolent ways of controlling her child's behavior, acquiring more education, and preparing for a specific career.

Although the family care programs we surveyed generally accept families on a voluntary basis only, once the women choose to enroll, participation in many of the services is required. Program staff say they want the women to commit to full participation in the program. The structure and discipline required to attend a regular schedule of classes and groups each day are also good preparation for later employment or education activities and the demands of child-rearing, say program staff.

At the same time, family care programs work individually with the women to make sure daily schedules are reasonable and to allow the women to proceed through treatment at a pace that is right for them. In addition to a core of required activities, many programs offer a menu of optional classes and activities designed to meet individual interests and needs.

Rainbow House, a domestic violence program in Chicago, appears to be unusual in that it has made all services optional. Program staff say that they want to give their clients as much control over their lives as possible because the women have had their behavior controlled by abusive partners for years.

Programs vary in the extent to which they provide services on site. **Women's Residential Services** is one of many programs that assure client participation by offering most services on site and providing transportation to off-site services. Other programs rely more heavily on services provided in the community, believing it is important for the women to learn how to use community services and to develop relationships with their staffs. **Seton Home**, for example, does not offer child care on site, preferring to give the young mothers the experience of choosing and working with community providers. Staff at the **Greentree Shelter** in Bethesda, Md., work hard to help families learn to use community services to increase their independence when they leave the homeless shelter.

Family care staff generally emphasize that they focus on participants' strengths rather than on their pathologies and base their treatment programs on rewards for accomplishments rather than on sanctions for shortcomings. Some offer material rewards. Young women at **Seton Home**, for example, receive extra bus tokens or stamps when they go a week without violating any rules. When residents at **Warren Village** in Denver do something beyond what is expected, they earn points toward a movie or restaurant gift certificate. When a teen mother at **Therapeutic Foster Families** in Chicago graduates from high school, the program buys her a dress to celebrate her accomplishment.

Many substance abuse and teen parenting programs use a system of levels, or phases, to mark progression though the program. As participants succeed at certain tasks, they advance to higher levels that provide more freedom as well as greater responsibilities. At **First Step Home** in Cincinnati, Phase 1 requires the woman to learn about her disease, establish a recovery program, and re-establish relationships with her children and family members. During Phase 2 (considered the most difficult), the woman's task is to get to know herself and to explore the core issues that kept her locked in active addiction. Finally, in Phase 3, the participant is expected to begin re-entering the outside world and preparing to establish her own home.

In the teen parent programs that used a system of phases, the residents often were challenged to progress through at their own pace, depending on their maturity. In the beginning, mothers had to demonstrate basic skills such as bathing and dressing their babies, cleaning their living space, and properly laundering clothes. They then were expected to learn about child development for their child's age group and put their knowledge into practice. They also had to master basic household chores and maintenance skills. In addition, the young women had to demonstrate interpersonal skills, including making friends and resolving conflicts peacefully. They later progress to mentoring new residents and assisting with other group activities.

Services for the Client as a Woman

Many services provided to clients are designed to strengthen the woman's self-image, so that she has a firmer foundation from which to nurture her children and cope with life's demands. Other services for the client as a woman help participants face unresolved family issues, work on personal relationships, improve basic life skills, attend to long-neglected health needs, and address their addiction or other special challenges.

Building Self-Image

Regardless of which type of family care program they enter, many family care clients share a history of abuse and have a badly distorted self-image as a result. To nurture and strengthen a positive self-image, family care programs help the women explore their self-perceptions through group discussions, written assignments, and art or dance therapy. Staff at **Crittenton Programs, Inc.**, in Wheeling, W. Va., for example, started taking teen parents to a local art center twice a week for pottery-making, quilting, and drawing. When it became apparent that the activities provided a valuable opportunity for therapeutic intervention, a trained art therapist was hired to staff the sessions. The director of **Grace Hill** described a technique where a program takes pictures of each client at her arrival and again upon discharge, encouraging her to tape the photos side-by-side on her mirror as a reminder of how far she has progressed. Some programs hold peer-led spirituality groups to discuss how religion has been helpful or hurtful to women's self-image. In some communities, churches offer family care residents regular rides to worship services.

Special activities also are undertaken to help foster participants' cultural identity. Family care programs typically seek some staff members with racial and ethnic backgrounds similar to the women and children they serve. Many programs weave cultural elements into the fabric of their treatment approach; some offer groups or classes on topics related to race or ethnicity, to help families reconnect with their roots. The New York homeless program, **Rose McCarthy Family Residence**, offers a weekly group for Black teen males, called IMAGE (Improving Male Images by Generating Excellence). At **Women's Way**, a substance abuse program in Honolulu, half of the clients are native Hawaiians for whom extended families are very important. Therefore, staff include extended family members in program activities whenever possible. In addition, treatment materials incorporate Hawaiian concepts, such as being in balance with God, nature, and other people. At another substance abuse program, **Women & Children's Residential Program** in

Fairbanks, Alaska, staff include a cultural history in the intake process and integrate American Indian parenting approaches into the parenting classes. **Women's Residential Services** in Libertyville, Ill., also a substance abuse program, offers a class called Effective Black Parenting.

At **Flowering Tree**, a substance abuse program located on a Native American reservation in Pine Ridge, S.D., staff members have found that many clients have lost ties to their culture and are excited to learn the reasons behind the traditions. On Fridays, which are called "culture days," the women learn about sweat lodges,

A New Life

"We have taken away all barriers to treatment."

It was her pregnancy in 1993 that brought "Sheryl" to A New Life, a community-based program for pregnant and parenting women suffering from addiction and their children, operated by the Crime Prevention Association of Philadelphia. "If I didn't have my daughter, I would still be out there," says Sheryl. A heavy crack user for years, she had tried treatment before but failed. Having lost custody of her first child, now a teenager, she feared she would lose the second. In 1996, Sheryl graduated from A New Life.

Sheryl began at A New Life while living in a shelter after finishing detox. She first lived in a mentor home, where a trained mentor helped keep her in treatment and moving forward in her new life. During the first 30 days in the mentor home, when no outside contact is allowed, Sheryl and her mentor had to go everywhere together. "They were on me all the time," says Sheryl. The mentors at A New Life are typically home-owning retirees who model effective parenting and other important life skills in a home setting. They are trained to encourage, listen to, and coach the young women, whose addictions are likely to have caused them to sever ties with their own families. "They're raw when they come to us," says one mentor, who began working for A New Life out of gratitude for the help her own son received from a community-based social service program.

While the mentor becomes part of the extended treatment team, the client becomes part of the mentor's extended family. Even when mother and child move from the mentor home to transitional housing after about 90 days, says one mentor, "We keep in touch with them and let them know they still have a family."

The Crime Prevention Association of Philadelphia began A New Life after it started a parent support program at the R.W. Brown Community Center and found that most of the participants had substance abuse problems that interfered with their attention to parenting. The idea of starting a treatment program was a leap for the agency, which had always focused on prevention, says its associate director, but the staff believes that truly serving the community means providing what it needs.

A three-year federal grant in 1991 from the National Center on Child Abuse and Neglect in the U.S. Department of Health and Human Services (HHS) made it possible for A New Life to take form. The program was designed to help homeless women coming from emergency shelters and mothers completing inpatient drug treatment. When the grant expired in 1994, program funding was picked up by Philadelphia's Coordinating Office for Drug and Alcohol Abuse Programs, and the city's Department of Human Services agreed to pay for child care and other services for participants' children.

Today, A New Life offers an intensive treatment program, and the staff who work directly with parents

Lakota parenting skills, and the role of women in Native American cultures.

Addressing Unresolved Family Issues

Family care programs recognize how important it is for clients to confront unresolved issues stemming from their family of origin, not only to aid their own recovery, but also to end the intergenerational pattern of family dysfunction. "The clients survive every abuse you can possibly imagine," says the director of the **Domestic Abuse Family Shelter** in Laurel, Miss. Incest and other sexual abuse, domestic violence, and substance abuse are

and children include a clinical supervisor, two primary therapists, a child development specialist, a family reunification counselor, and a life skills specialist. Mothers must get their children to the community center child care programs by 9:30 a.m., so they can participate in the educational groups focusing on substance abuse education, relapse prevention, life skills, and/or parenting that meet from 10 a.m. to noon. During lunch the women attend a Narcotics Anonymous group at nearby Temple University. They then participate in both group therapy and a parent–child interaction group in the afternoon.

Once a mother has made progress in her recovery and has strengthened her bond with her baby, program staff encourage her to re-establish relationships with her other children, who may be living with family members or in foster homes. A New Life staff help the women establish regular visits with the children and arrange for them to participate in the programs at the community center. "They're in a situation at the center where they can relax and be children and mom can be safe," says a staff member.

After about three months in a mentor home, mother and child move into one of the program's three transitional houses, each of which can accommodate three families. Consistent with the program's responsiveness to family's needs, A New Life added transitional housing when it became clear that the women's worry about finding housing at the end of their stay in the mentor home prevented them from concentrating on their recovery and often led them to leave early so they would not lose their spot on the waiting list for public housing. The Crime Prevention Association bought the first transitional house, but the city's Office of Emergency Shelter Services now funds all three houses, as well as the life skills counselor who works with the families to prepare them for independent living.

A New Life serves 35 families at a time, about six in mentor homes, nine in transitional housing, and the remainder in their own apartments. During their stay in transitional housing, parents continue treatment on an outpatient basis while they attend school or work, and their children remain in child care at the community center. While they live in transitional housing, parents pay 30 percent of their earnings for rent, and they must put another 20 percent in a savings account. Altogether, the program offers participating families about 18 months of treatment services, the goal of which is to help clients develop the skills that will allow them to live drug free in the community they came from.

Today, Sheryl has remained drug free for four years, has both of her children living with her, and has moved from transitional housing to a subsidized apartment. A recent graduate of a local community college, she is studying for a bachelor's degree in social work and received all A's during her first year. Sheryl works at the R.W. Brown Community Center during the summers and volunteers as much as she can during the school year. She also continues to participate in the family support program at the community center, and her younger child is still in child care there. She keeps in contact with her mentor as well as former and current participants from A New Life. Sheryl says that living on her own is not easy, but it is satisfying. "This is the first time in my life I've made money that's legal," she says, "and it feels good."

common in the birth families of women in family care. **Women's Residential Services** reports that at least 75 percent of its clients come from families in which other members suffer from addictions. At **Flint Odyssey House, Inc.**, a substance abuse program in Flint, Mich., 89 percent of the women report a history of sexual abuse and 71 percent report a history of other physical abuse. **Exodus** reports that almost half of its clients served in 1996–1997 reported physical abuse and 27 percent reported emotional abuse, but only 14 percent and 13 percent of these two groups had received any form of support or treatment prior to entering treatment. A third of the clients were homeless when they entered the program. A staff member at **Virginia Place** for homeless families in Lexington, Ky., estimates that up to 90 percent of the program's clients were abused in some way as children. Staff at **Crittenton Programs, Inc.**, for teen parents say that all of their residents have been abused, 89 percent sexually. "Pregnancy," says that program's director, "is just another symptom."

Some family care programs are able to offer a variety of assessments, individual therapeutic interventions, and peer counseling sessions to help each woman understand her own family legacy. **First Step Home** in Cincinnati helps clients create a kind of annotated family tree, called a "genogram," to trace intergenerational patterns of behaviors and difficulties that clients have not previously identified. **Seton Home** in San Antonio hired a sexual abuse therapist to lead weekly groups and conduct individual counseling on-site for its teen mothers.

Because family care programs typically offer longer and more flexible limits on length of stay, clients have the time and safety to explore issues that are unlikely to surface in a 30-day shelter or treatment environment. One family care program director says that since shorter, more traditional hospital treatment programs fail to "address the underlying issues, the women start using again the day after getting out of treatment." The psychological work that many family care clients undertake allows them to build a sturdier foundation from which to nurture their own children.

Yet limited funding and, in some cases, severe restrictions on grant money prevent some programs from allocating resources to help participants confront the underlying issues that have contributed to their current difficulties. Often programs are able to help women recognize their need for additional psychological services, even if the programs lack the resources to provide them themselves. **Middle Way House** for families experiencing domestic violence in Bloomington, Ind., conducts a substance abuse assessment for all of its clients, for the purpose of sharing the results with them.

Strengthening Relationships

As a staff member at **Women's Residential Services** notes, clients in family care typically "do not know what a healthy relationship looks like," so many programs offer groups on relationship issues, such as co-dependency, assertiveness, interpersonal communication, sexuality, anger management, and conflict resolution. In addition, family care programs assist their clients in reconnecting with family members, including the men in their lives (provided they are not batterers), if the women so choose. The **Pregnant & Postpartum Women & Infants Program** in Chicago that serves families facing substance abuse makes "developing and negotiating family relationships" one of its program goals.

Women's Residential Services, like other programs, finds that "clients with family involvement do better in the program than those without." Some substance abuse and teen parent programs hold what they call "family days" and allow family visits on weekends. Some programs also offer groups to help family members understand addiction, support groups for couples, or family therapy. **Families in Transition**, a substance abuse program in Miami, has a family coordinator on staff assigned to reach out to participants' extended support structures.

Seton Home requires parents or guardians of the pregnant teenagers to be present at the client's assessment, and one-quarter of the families are reunited as a result. However, most reconciliations between pregnant teens and their families occur after the birth "because then it's not your pregnant teen [who is the concern], it's your grandbaby," says the former director.

The parent agency operating **New Empowerment**

Alternatives for teen mothers and their children in Newark, N.J., has a particularly exemplary outreach arm for young fathers. Through its First Steps and Operation Fatherhood programs, weekly peer support groups provide an opportunity for the men to talk about their role as fathers and how best they can support their children. Group father–child outings are arranged, job readiness classes are offered, and even an agency "job coach" is available to help the fathers get and keep jobs. A portion of the wages of each of the participants in Operation Fatherhood is garnished automatically for child support. Staff say the program teaches men how to be responsible for their children and involved in their lives.

Teaching Life Skills

Classes that teach clients such skills as cooking, budgeting, reading utility bills, time management, and home maintenance are important service components in nearly all family care programs. Although some family care clients have had experience running a household, others are teenagers with little life experience and still others come from such unstable and disorganized backgrounds that they never learned the basics of maintaining a household. Gaining the skills to run a household adequately enhances clients' self-esteem and gives them confidence they can make it on their own.

Residents put their newly learned life skills to use immediately. They are expected, for example, to master the morning routine of getting their children up, dressed, fed, and off to child care on time, so they themselves can go to work, attend school, or participate in program activities. **Seton Home** decided not to provide transportation help for their teenage mothers. Unless the mother or her baby is sick, says a staff member, "she has to hop on the bus, take baby to day care, then go to school, and at the end of the day, do the reverse." At **HerStory House** in Rutland, Vt., the clients must make their own calls to the doctor or the welfare office, for example, or to prospective landlords. However, finding safe and affordable housing is a such a difficult goal to achieve that many programs dedicate a staff member to assisting clients with their searches.

In addition, clients are expected to do their part each day to make the family care household run smoothly. For example, in most programs, cooking dinner for the group is a rotating responsibility of the clients, although in the larger programs, especially, a paid cook may oversee the effort. **Flowering Tree** requires its graduates, who are typically American Indians, to know how to make a quilt and bake a favorite traditional bread called *gabooboo*. "That way," explains a staff member, "they can always sell the quilt at the end of the month to [buy the ingredients to] make *gabooboo* bread to feed their kids!"

A number of programs, like **Comprehensive Treatment Services** in Newton, Kan., ask clients to contribute, on a sliding fee scale, toward the cost of services and rent. No matter how little the women have, says a staff member, paying for services gives the women an important sense of ownership and helps move them toward independence. Paying some money can also get families used to setting aside a portion of their income as they learn to budget. At **Warren Village** in Denver, families are asked to contribute 30 percent of their income for rent.

Promoting Good Health

Women are often in poor health and suffer from a variety of untreated medical problems when they enter family care. Most programs offer some health services, either through a relationship with a local hospital or at their own on-site clinic. Many programs have a nurse on staff to conduct health assessments, offer family planning services, and screen for tuberculosis and other diseases. A staff member at **Flowering Tree** says, "A lot of the women do not have teeth as a result of domestic violence or no dental care, so one of the first things we do, we get them teeth."

In many programs, a doctor or other health practitioner visits regularly. **Virginia Place**, a program at the University of Kentucky for single parent students who need housing and other supports, provides the services of a family nurse practitioner one day a week, through the school's College of Nursing. The College of Dentistry offers free dental care to participants and their children.

Programs generally encourage women to take responsibility for their own health by offering a women's health group, and some even provide indoor exercise rooms. **Women's Residential Services** offers an aerobics class three times a week and a nightly relaxation group.

In addition to physical health problems, many family care clients suffer from mental health problems such as depression and post-traumatic stress disorder. About half of all women at **Women's Residential Services**, for example, are diagnosed with both a chemical addiction and a mental disorder. Since most family care programs do not have a psychiatrist on staff, they usually refer clients to mental health services in the community. Many family care providers we surveyed mentioned the ongoing challenge of addressing mental disorders; they all agree it is an area in need of increased attention.

Providing Specialized Services

Most of the family care programs for recovering substance abusers, victims of domestic violence, and teen parents that we surveyed provide a combination of many of the services described above. Programs for homeless families typically offer a less comprehensive menu of services. In addition, each program typically offers more specialized services to address the specific needs of its target population. In the next few pages, we summarize the more specialized services that different types of family care programs offer their clients.

Women recovering from addiction

Our survey suggests that family care programs for women with substance abuse problems offer the most comprehensive services and the most challenging regimen of activities. For residents of these programs, treatment is nearly a full-time job. (See box on pages 32–33.) Women at **Exodus** in Compton, Calif., for example, are required to engage in five and a half hours of treatment every day except Sunday. Clients typically attend daily support groups, as well as weekly classes on addiction, relapse prevention, and drug education. For additional peer support, **Exodus** and most programs link participants with local 12-step self-help programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). At **Exodus** two such groups are available on-site each week. Initial and random urine screenings also are provided. In program year 1996–1997, random drug testing occurred at least bi-weekly for each client; only 1 percent or all drug tests were positive for one or more drugs.

Organized recreation also appears to be an important component of programs for women with substance abuse problems and their children. As the staff member of **Women's Residential Services** explains, family activities such as roller skating, swimming, and picnics are held to allow clients to learn to play with their children and how to socialize without drugs or alcohol.

Although none of the family care programs we surveyed accept women who are actively abusing drugs or alcohol, most programs find that they must deal with their clients' relapses. The approach taken by **Teen Parenting Services** in Portland, Maine, seems to be shared by many programs. "Our attitude," says a staff member, "is that you can relapse, but you can [also] recover. We're not black and white about it." In such cases, staff help the women identify what triggered the relapse, think about how to avoid similar situations in the future, and prepare a safety plan to protect their children should they relapse again. At **Exodus** relapse prevention and lifetime aftercare services are crucial elements in programming in order to increase the likelihood of long-term recovery. Their relapse prevention strategies include skill training, behavioral management, social modeling, cognitive restructuring, and lifestyle modifications.

Victims of domestic violence

The core of services for women fleeing domestic violence is generally a peer support group led by a professional. In some cases, women may attend several of these groups each day; in other cases, women attend once or twice a week. **HerStory House** offers the same class three times a day, to accommodate clients' varied schedules. Group leaders typically help the women understand the dynamics of domestic violence and to help build the women's self-esteem. Legal advocacy also is provided to help women navigate the legal landscape surrounding court-ordered protection and child custody rulings.

Whatever setting a participant in **Domestic Violence Intervention Services, Inc.**, moves into following her stay at the Tulsa, Okla., program, staff members help her devise a safety plan for herself and her children. Given the difficulty of finding alternative housing and severing intimate relationships, it is not unusual for a client to return to her abuser several times before leaving permanently, says one staff member, but that does not mean the program has not helped. "It is not necessarily a failure [when she returns to the abuser], but rather part of the process."

Homeless families

Unlike emergency shelters, which provide families very short-term housing before they are forced to leave, family care programs for this population try to help their clients tackle the underlying problems that led to homelessness. At the same time, they help clients find and keep permanent housing and jobs. As we noted earlier, the staffs of these programs report that many of their clients, in addition to being homeless, struggle with the consequences of domestic violence or substance abuse, or both. At **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., about one-third of the women who entered the program in 1996–1997 came from domestic violence situations. Consequently, the programs offer classes and support groups related to domestic violence and substance abuse. Parent participation is generally voluntary, although a few programs, like **Warren Village**, require residents to attend a certain number of groups of their choice each month.

Pregnant and parenting teens

Family care programs for this population face a unique challenge because their clients, as well their clients' offspring, are children. As a staff member at the **Adolescent Mother–Baby Program** in Hyattsville, Md., puts it, "We're trying to make sure the child gets what he needs from someone not [developmentally] ready to give it to him."

Many pregnant teens are wards of the court. **Therapeutic Foster Families** in Chicago serves only wards, many of whom have been in multiple foster placements prior to coming to family care. A **Crittenton Programs, Inc.**, staff member says that many of their teen clients tell them, "This is the closest thing I've ever had to a home." For some young women, says this staff member, "this is their longest placement anywhere." Even when the teens are not wards, their parents or guardian must temporarily relinquish custody to the family care program because the young women are still minors. The teenagers, however, retain custody of their children.

Predictably, discipline is a major challenge in these family care programs. According to a **Seton Home** staff member, the teenagers severely test the program rules and staff for the first few weeks, trying to find out whether "you care enough to do what you say you will do, or [whether you are] just blowing smoke like everyone else in my life." Trust develops, says the staff member, "when [the teens] know that people will keep their word." (See box on pages 20–21.)

Since "it's part of an adolescent's job to reject authority, it does not work simply to lay down the law," says a staff member at **Teen Parenting Services**. By helping the teens examine the potential consequences of their actions, program staff try to help them figure out for themselves why some behaviors are preferable to others. "We try to get them to think," she says.

The staff make sure each participant goes to school, gets enough rest, eats healthy meals, and receives prenatal care. (Many young women receive no prenatal care before entering the program.) Childbirth and infant care classes are offered, often in collaboration with a local hospital, and family care staff members nearly always serve as the young women's labor coaches. In many programs, volunteers act as mentors, foster grandparents, or child care aides for the teens and their babies. At **Bridgeway** in Lakewood, Colo., each resident is assigned a mentor family called a "bridger." Bridger families agree to spend six to eight hours each month with the teens, taking them out to dinner or to community functions, or inviting them to spend time with them in their homes. Although the mentors are helpful, says a staff member, the sharing and mutual support among the participants themselves "accounts for 90 percent of the value of the program."

Seton Home

"These children have chosen to parent, with or without our help. How healthy that new family will be is the question."

Pregnant teens find themselves seeking refuge at Seton Home in San Antonio at what is perhaps the most frightening and challenging time in their lives. "Christie's" parents forced her to leave home when they learned she was pregnant. She ran away with her boyfriend but became desperate to find a safe place to live when he became abusive. Just before her baby was born, she learned about Seton Home, after trying other places that "kicked you out two days after giving birth." "Maria," pregnant at 14, had no other place to go either. She came to Seton Home begrudgingly from a group home, after the state had removed her and her siblings from an abusive family situation. Since 1981, Seton Home has taken in over 900 pregnant teenagers like Christie and Maria, with the goal of saving two generations at once.

From its beginnings as a maternity home, Seton Home has expanded its scope to become the only program in the state providing comprehensive services to teenage mothers and their children. The young women are encouraged to live at Seton Home until their babies are at least 2-months-old, and many stay longer. One-quarter to one-half of the teens in residence at any one time are wards of child protective service agencies, and for many this is their longest placement since becoming wards of the state. The home becomes the legal guardian for the teen parents while they are there but receives no funding for their babies, who remain the parent's responsibility.

The parents who still have custody of the teens at Seton Home must participate in their daughters' original intake assessments and consent to their residence in the home. Many estranged families can reconcile over the course of their daughters' stay at Seton Home, although they might not live together again.

The staff work hard to strike the right balance between nurturing the young women and setting limits, and the program's rules give structure to the teens' lives, often for the first time. "Probably the hardest thing to do," says the director of social services at Seton Home, "is to nurture the young moms yet be tough enough to set the limits, boundaries, and expectations needed to foster the mom's ability to nurture her child. They have to grow up so quickly and have had so little modeling."

In addition to caring for their infants, the young mothers must go to school. They are responsible for finding child care and getting their babies there each day, as well as to doctor appointments. The young women must also participate in classes on daily living skills, goal-setting and decision-making, alcohol and drug abuse prevention, and parenting, and must attend individual and group counseling. As a group, the young mothers are responsible for planning the meals, and each one must cook once a week.

As a result of these programs' efforts to promote healthy pregnancies, many can boast of good birth outcomes. **Seton Home**, for example, is proud that babies born there weigh, on average, one pound more than the typical baby born to a U.S. teenager. When former clients bring their babies back for quarterly well-baby checks, 100 percent are up-to-date on their shots.

Like most family care programs, those for teenagers often offer classes and groups in the evening. Staff at **Crittenton Programs, Inc.**, say the most intense staff–client interactions take place in the evenings, while the babies are being bathed or during informal kitchen table conversations between one or two girls and a staff member.

Staff say that it is not just the curriculum that helps turn out responsible parents and adults; it is also the daily, positive peer support the girls get from each other. All of them come to Seton Home wanting to give their babies a good start in life, and they help and encourage each other along the way. Because the girls arrive at the home at different stages in their pregnancies, those who are farther along or have already given birth help mentor the others. For example, since Christie already had her baby, she was able to help Maria with bathing and other tasks after Maria's baby was born.

Like staff at family care programs serving other target groups, the Seton Home staff began to recognize that many teens who completed the program risked going back to the same difficult living situations they had fled, threatening all of the progress they had made during their residence. So in 1997, the program opened a brand-new, eight-unit transitional housing apartment complex for girls 16- to 18-years-old, who are too young to sign leases of their own. They are allowed to stay up to two years while they finish school and start employment. An independent living skills instructor lives on site to continue supervising and supporting the young women during their transition to adulthood. Residents must pay 25 percent of their state assistance or other income for rent and put aside a set amount each month for savings.

Wherever the teens decide to live after graduating from Seton Home, they are welcomed back to the quarterly aftercare program, which includes parenting classes, well-baby checks, and opportunities to receive baby supplies. A photographer from a local studio in the area takes and donates family portraits to the mothers, often the only ones they will have. Even though it is common for the teens to be eager to leave the program and its strict rules, many come to visit or call frequently between the quarterly reunions. Some even ask to return to the program after being on their own for a few weeks.

Christie and Maria are somewhat unusual graduates of Seton Home, in that both returned to their parents' homes several months after their babies were born. Christie, who struggled to learn how to control her anger while in the program, now has a job and is taking classes at a nearby community college. Her child is thriving. Maria is back in school, although she describes her home situation as shaky.

The investment that goes into the young mothers at Seton Home pays off for the babies as well as the mothers. The program's insistence on complete prenatal care means that the average birthweight for each child born at Seton Home is one pound above the national average for teenage births. Among clients who participate in the aftercare program, 100 percent have had their children fully immunized.

"We see we are breaking many cycles of dysfunction," says the former executive director. "These children have chosen to parent, with or without our help. How healthy that new family will be is now the question." Seton Home is trying to make sure the answer is "very healthy."

Services for the Woman as a Community Member

In addition to offering clients help in dealing with personal issues, family care programs assist them in taking steps toward becoming responsible and participating members of their communities. For example, programs generally provide women links to education or job training activities, introduce them to a variety of community resources, and require those with school-age children to become involved at their schools. Some even require clients to perform some kind of community service.

Obtaining Education, Job Preparation, and Employment

The women enrolled in family care typically face tremendous odds when it comes to supporting their children, since few have much job experience or education. Persistent poverty was often described as an undercurrent in many of their lives. Now, the 1996 welfare law leaves them little choice but to find work. Family care providers are faced with helping some of the most vulnerable families get a job whether they are ready to or not. Although job development has been a stronger focus in some family care programs than others, the 1996 welfare law promises to push the issue more to center stage in the coming years.

A number of family care programs, particularly those focusing on teen pregnancy, domestic violence, or homelessness, already require participants to be enrolled in school or job training or to be employed. At **Doméstic Abuse Family Shelter** in Laurel, Miss., women must be going to school, volunteering, or employed after two weeks in the program, and at **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., parents must be employed within 30 days. All of the teen pregnancy programs we surveyed required their clients to finish high school or obtain their general equivalency diploma (GED).

Some programs, including **Families in Transition** in Miami, try to encourage their clients to continue their education rather than take low-wage jobs, since education is likely to lead to greater economic security in the long run. Until recently, some women had been able to choose this education option because Florida offered a special program for welfare recipients, under which the state paid for courses and books if they maintained a passing grade average. Yet even when it was available, many women were not ready to make a long-term commitment to education, says a staff member, because they were used to focusing only on day-to-day survival.

Generally, family care programs rely on existing community resources to provide education and job-related services, but a few offer education or job training on site or through a parent agency. **Crittenton Programs, Inc.**, in Wheeling, W. Va., operates a five-room alternative high school in which the therapeutic program is integrated within the education curriculum. The local school district supplies one teacher, and the program supplies another. **Middle Way House** for victims of domestic violence in Bloomington, Ind., used a special grant to establish a microenterprise system that gives clients the opportunity to start their own businesses with no-interest loans from a local bank. The parent agency of St. Louis's **Grace Hill** program for women recovering from substance abuse offers nearly 50 free courses to program residents and other members of the community through its Neighborhood College. Classes include small business planning, home weatherization, health aide training, environmental studies, and leadership training.

Grace Hill and a few other programs we surveyed offer temporary on-site employment at the parent agency, to help women develop a work history. The agency pays clients their wages upon discharge, so they have a nest egg to help them with their transition to independent living. **Teen Parenting Services** in Portland, Maine, offers stipends and on-the-job training for residents willing to clean the building four hours a week.

Engaging in Community Activities

Many programs make a point of introducing participants to the resources available in the community, including self-help groups like AA and NA, health clinics, libraries, parks and recreation facilities, and after-school programs. Participation in off-site programs is important, says a staff member at **Women's Residential Services**, in Libertyville, Ill., because it helps the women "find a potential support system out in the community they can return to when they leave [the program]."

Some of the programs we surveyed require women with school-age children to talk regularly with their child's teacher and participate in special school events. A client at **Families in Transition** became so involved at her child's school she was named "Parent of the Year."

To encourage clients to see themselves as contributing members of the community, in addition to being users of services, some family care programs provide leadership development activities. At **Virginia Place** in Lexington, Ky., all participants are members of the residents' council, where they gain valuable experience in group problem-solving and decision-making. Some family care programs ask former clients to join their boards of directors.

We also found several programs that require their clients to do volunteer work in the community. At **Seton Home** in San Antonio, for example, the teen mothers visit the residents of a local nursing home, bringing along their babies and home-baked cookies.

Toward the end of residential treatment and during aftercare, program staff also encourage clients to reach out to former clients and sympathetic family and community members, to begin building a personal support network that will be available to them as they rebuild their lives.

Many family care programs operate within a parent agency that provides a variety of other services to the wider community: **HerStory House**, a domestic violence program in Rutland, Vt., operates a food pantry; **Domestic Abuse Family Shelter** sponsors parenting classes for the general public; **Women Helping Battered Women** in Burlington, Vt., offers a course to local high schools on dating violence; and Homes for the Homeless in New York makes its crisis nursery available to the larger community. A number of agencies that run domestic violence programs offer separate treatment for batterers. Some programs even enlist their staff to provide training to larger institutions in the community. The **Domestic Abuse Family Shelter**, for example, has developed a curriculum and training manual to educate judges and law enforcement personnel within the 11-county service area about domestic violence. They focus on the importance of mandatory arrests and court-ordered counseling, as well as the services offered by their parent agency.

Support and Services for the Woman as a Mother

Women's effectiveness as parents varies when they enter care, say family care staff, but virtually all clients can benefit from parent training and mentoring, since even the practices of the more skilled parents tend to reflect strains related to their stressful circumstances. "During this time," says a staff member at **Domestic Violence Intervention Services, Inc.**, in Tulsa, Okla., "a parent's ability to nurture goes down, and the needs of the child go up."

As we have noted, family care programs are uniquely committed to helping their clients become more nurturing and effective parents, although our survey suggests that many programs are still working to achieve the optimal mix of parenting-oriented services, children's services, and treatment for their adult participants' primary problems. Combining high-quality parenting education and children's services with treatment and services for the mother is more complex and expensive than offering traditional treatment, and it is already difficult to find staff skilled in working with women recovering from substance abuse, say family care administrators. Programs generally must hire at least one special staff person to work with the children and oversee parenting education, since staff traditionally trained in substance abuse treatment usually do not have expertise in children's services.

The programs we surveyed that offer the richest menu of parent education and children's services appear to work simultaneously on three levels, though with considerable variation in emphasis. First, the programs educate, encourage, and support participants in their role as parents. Second, they consciously focus on the mother–child dyad, providing daily and immediate hands-on modeling and guidance to improve parent–child interactions and help heal wounded parent–child relationships. Third, they also provide services that help the children cope with and overcome the consequences of their difficult past.

Here, in one integrated discussion, we describe the first two levels of effort—parenting education and support and assistance with parent–child interactions. In the next section we describe services for children.

Assessing Parenting Capacity

Among the 50 family care programs we surveyed, 43 assess the parent–child dynamic at intake. **PAR Village**, a substance abuse program in Largo, Fla., for example, uses a parenting stress index to help evaluate the quality of each parent–child relationship. The **Flint Odyssey House, Inc.**, in Flint, Mich., employs an infant mental health specialist to assess early family dynamics in its families who have substance abuse problems. Whether or not they conduct formal initial assessments, however, most programs include some combination of family therapy, supervision, and guidance of the daily interaction between parent and child, formal parent–child interaction sessions, modeling of parenting skills by staff, parenting classes, and peer groups.

Some women recovering from addiction enter family care alone, and their children in foster care join them within a month or so after the women have completed the stabilization phase and appear likely to stay in the program. At **Comprehensive Treatment Services** in Newton, Kan., staff estimate about 15 percent of the mothers facing substance abuse are not stable enough to care for their children. Another 25 percent are stable enough that they come in with their children. The majority, 60 percent of the mothers who come in without their children, are reunited over the course of treatment.

Sometimes reunification can be difficult for both mother and child. In some cases, children were born drug-exposed and have been separated from their mothers since infancy. A staff member at **Women's Way** in Honolulu says, "A lot of women have a lot of guilt for using while pregnant. The mom is angry that the child was taken away [and has] fears about reconnecting with the baby and parenting." Sometimes, says a staff member at **Women's Residential Services**, in Libertyville, Ill., "the mom is so excited to be reunited with the child, and the child does not respond well, and that's devastating." To ease the adjustment, a gradual reunification plan may be developed that includes periodic supervised parent–child visits and family therapy. **Women's Residential Services**, for example, holds a support group twice a week to help build the parent–child relationship through games and other process-oriented activities.

Family care staff say they make a great effort to affirm their clients' identity as mothers, since these women often have low self-esteem regarding their parenting abilities. Battered women often feel guilty for the violence their children have experienced. Mothers with a history of substance abuse hear society's message that a "good" mother would not be an addict. Young teenagers are well aware that they are considered too young to be "good" mothers.

In the safe environment of family care, women gradually are able to acknowledge their guilt feelings and move beyond them. Substance abuse programs, for example, may help mothers whose children suffer from fetal alcohol syndrome to understand their children's problems and turn their guilt into determination to get their children the special help they need.

The staff at **Flint Odyssey House, Inc.**, for women recovering from substance abuse have developed a poignant Mother's Day ritual to strengthen their clients' commitment to their parental role. They ask each woman to write down her thoughts on "what is important about being a mother." Each woman is then given a rose and asked to share what she has written. The staff says many women express joy at being recognized as mothers and seeing themselves once again as nurturers.

Family care program staff find that most of their clients were never adequately nurtured and do not know how stable, nurturing families operate. Therefore, staff try to make their programs approximate caring families. A staff member at **HerStory House** in Rutland, Vt., says, "We try to live and act as a family. Teaching respect for other people is very important, and the staff does a lot of modeling. How can you expect a mother to nurture if she has never been nurtured?"

Strengthening Parenting Skills

Family care typically offers classes, discussion groups, and peer support groups to help mothers understand children's emotional needs, learn about child development, and develop age-appropriate expectations for their children. Many clients do not know how to talk and play with young children and many lack information about hygiene, discipline, and nutrition, say program staff. A staff member at the **Women's & Children's Residential Program** for substance abuse in Fairbanks, Alaska, says that some clients, for example, "have been feeding a 5-year-old's meals to a 2-year-old."

In addition to teaching child-rearing skills, staff at **G.A.P.P. Family Enrichment Center** in Atlanta, a substance abuse program, help mothers learn such basics as how to collect the things a child needs for school, how to prepare for a doctor visit, and what to tell a babysitter. At **PAR Village**, women learn infant/child cardiopulmonary resuscitation (CPR) and first aid.

Staff members from many programs report that child discipline is a frequent topic of discussion. Spanking and hitting generally are not allowed in family care programs, and this stricture presents a challenge for parents. A staff member at **Rainbow House** in Chicago explains: "We're asking them to come into this foreign environment, and then we say, 'Oh, by the way, no physical discipline of your children.' 'What?' [says the mother]. 'I'm already feeling so little control, and now [I have] no control over my kids?'" But unlike many traditional family shelters that impose such a rule, family care programs also help parents identify and practice nonviolent forms of child discipline and better ways to change behavior. A staff member at **Teen Parenting Services** in Portland, Maine, says, "We have a great deal of discussion about what it feels like to be a child [in relation to] an adult hand that can be hurtful."

Modeling Effective Parenting

Although parenting classes and peer discussion groups are important, say program staff, what is unique about the family care setting is the opportunity it provides for staff to model effective parenting behavior and to supervise parent–child interaction. Family care allows for on-the-job parenting training, and staff say that some of the most meaningful learning occurs in the course of parents' routine interactions with their children, when program staff are present to model and assist.

At **Teen Parenting Services**, says a staff member, "staff may subtly just take a child and soothe them. And the parents pay attention." One staff member in this program is a man "who models loving, warm, affectionate fathering. The teens respond so incredibly to that," says a staff member. "They're used to fathers being cold, tough, and hurtful."

Program staff often observe that clients do not know how to play with their children, and a staff member at **Comprehensive Treatment Services** recalls that a mother did not know how to hug her child. A staff member gently took the mother's arms and placed them around the child. Recognizing that many women had no experience with appropriate touching during their own childhoods, several family care programs, including **Crittenton Programs, Inc.**, in Wheeling, W. Va., offer infant massage workshops to teach the teen mothers how to give their children positive touching.

In most family care programs, parents have a chance to practice their newly learned parenting skills with guidance and supervision. Many set aside activity time for parents and children together, when counselors and mentors are available to observe and guide the their interactions. **Women's Residential Services** offers twice weekly groups for mothers and their children, designed to foster healthy family relationships through game-playing and other process-oriented activities. In the parenting classes, instructors have an opportunity to comment on the situations and interactions that occur in supervised parent–child sessions and during the course of each day.

Promoting Daily Routines

On a practical level, many family care programs require parents to follow a specific daily schedule with their children. The idea, say program staff, is to introduce structure and predictability that will survive the transition to independent living. The routine established by family care programs often provides many clients with the first structured living environment they have ever experienced.

Families are required, for example, to adhere to set mealtimes. At **Families in Transition** in Miami, there is no TV watching during meals, and each family eats at its own table, says a staff member, "so they can get used to being a family." All of the family care programs we studied have set bedtimes to give the children's lives consistency and predictability. The director of **HerStory House** explains, "Most kids are not at all used to this. They fall asleep in front of the TV at home around 11 o'clock, when they cannot sit up anymore." According to the director of this domestic violence program, parents say how much they appreciate having a few hours in the evening without their children and vow to continue setting a bedtime after they leave the program.

In many family care programs, the daily schedule includes some family time for parents and children. At **Women's Way**, mothers spend the first hour of the morning playing with their children in the therapeutic nursery. But more typically, family time is scheduled before dinner. "We added a parent–child activity time when we realized [the children] needed some structured bonding time, instead of being whisked from day care to bed," says a staff member at **Pregnant & Postpartum Women & Infants Program**, a substance abuse program in Chicago.

Deciding Not to Parent

Although family care was created to strengthen families while mothers receive services, some women—especially among those in substance abuse treatment and, to a lesser degree, those in programs for pregnant and parenting teenagers—decide during treatment that they do not want or are not able to raise their children. Family care staff take pains to create an environment in which a client can make such a decision, have it respected, and receive help in executing it. Yet a few women in this situation, according to program staff, try to avoid facing the pain head-on by sabotaging their treatment, so the state will deny them custody, and the women can then blame others for the loss of their children. "There is such an expectation placed around motherhood," says the director of **Women's Residential Services**. "Some do not want to be a mother, but because of how our society is structured, it's not right for parents to give up their children. You're [seen as] a really a bad person if you do not want to be a mother."

At **Bridgeway** in Lakewood, Colo., the staff try to help their teenage clients make thoughtful decisions about whether to parent their children by making sure they interact regularly with program participants who have already had their babies. Hopefully, say the staff, this firsthand view of what it means to be a parent helps their pregnant clients think more realistically about what is in store for them.

Services for Children

Family care programs increasingly recognize the child as a family member with separate needs, whose well-being also must be ensured if the family unit is to be preserved. As a result of acquiring experience with families in the residential setting, staff say they gradually have come to understand the intensity of the children's needs and the importance of addressing them directly. In the early days of their programs, say a number of family care staff, they primarily offered child care for the children of their clients. But soon it became clear that simple babysitting would not meet the children's needs. A staff member at the **Domestic Abuse Family Shelter** in Laurel, Miss., says the program revised its mission statement six years ago to "upgrade the children's status from being secondary victims to being primary victims, and then acted accordingly."

The programs we surveyed still vary significantly in the amount of resources they dedicate to children. Many programs now have at least one staff member concerned solely with children's needs, and a few provide nearly as many services for the children as they do for the adults. But other programs still offer little more than child care and after-school recreational activities. Still, the programs show a positive progression toward a more well-equipped children's component. In 34 of the 50 programs surveyed, children are formally assessed at intake so staff can develop an individual service or treatment plan. Twenty-seven offer after-school programs, many of which include academic tutoring. Thirty-four offer either therapeutic or developmental child care above and beyond the babysitting variety.

Typically, the children show the emotional and behavioral consequences of their traumatic lives. Children of domestic violence victims, for example, are likely to exhibit the symptoms of those who have witnessed or experienced violence, even when they have not been physically abused themselves. Children of women addicted to drugs or alcohol may suffer from physical effects and sometimes from the consequences of emotional and physical neglect. Homeless children may be anxious and insecure as a result of living in stressful, overcrowded conditions and having no place to call home. A staff member at **Women's Residential Services** in Libertyville, Ill., where the clients are struggling with substance abuse, says that "most of the children are socially and emotionally withdrawn when they come to the program. Initially they seem to be fearful of their mothers. They are used to very inconsistent parenting."

The director of the **Rose McCarthy Family Residence** in New York, for families who are homeless, observes that some children have reacted to their family situation by assuming a parental role. They routinely care for younger siblings—and their mother, if she is addicted—and try to protect their mother from their father's violence. Staff members from a number of programs say that many of the children have forgotten how to be children.

Many children are angry. The mother's substance abuse and its consequences often are the source of their anger, but not always. At **Comprehensive Treatment Services** in Newton, Kan., staff estimate that about 25 percent of the children have been sexually abused. "They have a right to be angry," says a staff member. "They do not know where the anger is coming from, so they're destructive."

Program staff also find that some children are angry as a result of the move into family care. Sometimes, when a mother and children flee domestic violence but the abuse has been targeted only at the woman, the children blame the mother for disrupting their lives. A staff member at **HerStory House** in Rutland, Vt., recalls the children of one woman who fled to the shelter. They were "angry they had to leave their home, their dad, their dog, their neighbors, familiar school, and friends."

Providing Treatment

In general, says a staff member at **Women's Residential Services**, the children go through many of the same stages in treatment as the mothers do. About the third week, the children typically begin to act out, "testing their mother to see if she will leave, as she has probably done in the past." Initially, the children minimize their difficulties, but eventually "they deal with the problems that they and their mothers have." What is gratifying, says this staff member, "is that the children tend to feel as comfortable with their mothers by the end of treatment as they do initially with the staff."

Many family care programs have a therapeutic nursery staffed to provide developmentally based child care, along with therapies based on art, movement, and play for different age groups. Programs also may offer educational and therapeutic support groups for school-age children, to help them understand and talk about addiction, domestic violence, or homelessness. A number of programs conduct psychological evaluations that are used in treatment planning. As with the adults, children with psychiatric disorders are typically referred to services outside of the program for additional treatment.

Some programs require a minimum of 20 to 25 hours of weekly therapeutic intervention for children in substance-abusing families. At **Women's Residential Services**, the cornerstone of the children's program is the "Children of People" group, which operates under the motto: "Chemical dependency is a disease. I didn't cause it. I cannot cure it, but I can learn to cope." Among other things, the group teaches children effective methods of coping with stress, to help prevent them from developing alcohol and drug problems and other self-defeating behaviors themselves.

In many cases, children have never before had anyone to talk with about family problems—not even their parents. **Women's Residential Services** reports that mothers often do not realize how aware their children are of their drug use. A staff member at **HerSpace**, a domestic violence program in Washington, D.C., says many clients initially have a hard time understanding the effect on children of observing spousal abuse, if the children themselves were not hit. At that program, the children participate in group therapy while the mothers are meeting in their own therapeutic group.

In the therapeutic children's group at **HerStory House**, children who have been sexually abused are helped to talk about it—sometimes for the first time. "Many children are too terrified of the [physical] abuse to reveal the sexual abuse," says the staff member who leads the group and also offers individual counseling. She helps the children develop healing strategies that will allow them to build nurturing, trusting relationships in the future.

Recognizing that the children they serve may be particularly vulnerable to sexual abuse, staff at **Women's Residential Services** offer a group to teach self-protection and respect for one's own and others' bodies. **Middle Way House**, a domestic violence program in Bloomington, Ind., offers separate classes for teenage

Greentree Shelter

"We need to foster the developmental steps they never had the opportunity to take."

As a single father, "Howard" came to Greentree Shelter in Bethesda, Md., with a teenage daughter and two young sons. He had a history of alcohol abuse, which had cost him his job as a janitor and the apartment that went with it. The choice of Greentree Shelter was fortunate for Howard and his children because it not only provides shelter for homeless families, many of whom are also recovering from substance abuse and domestic violence, but also helps them take the necessary steps to self-sufficiency they may have missed.

The staff at Greentree Shelter, which is run by the Baptist Home for Children and Families, know that the key to a permanent home and self-sufficiency for homeless families involves more than getting a job. Adults whose childhoods were marked by abuse or family chaos often lack some of the developmental mastery that is necessary to create a stable and successful life. They do not know how to plan ahead, set goals, and focus on taking the small steps necessary to achieve those goals. Greentree Shelter helps parents develop these building blocks and begin using them to build new lives. "Changing lifelong behavior is a slow process filled with setbacks," says the program's assistant director. Like their children who try to build towers with blocks, she says, parents "get frustrated and often unintentionally knock them all down, destroying what they initially accomplished." But the Greentree Shelter staff help parents gather up the blocks and find the strength to start over.

"The 1996 welfare law has made it necessary for the shelter staff to change the way they help residents plan for the future," says the assistant director. In the past, staff encouraged parents to consider what would give them the most stability—whether that was getting a GED, enrolling in a community college or technical school, or caring for their young children at home. Now, under the 1996 welfare law, parents must concentrate on finding a job as soon as possible. Parents who aspire to better paying jobs must juggle night and weekend classes with work and parental responsibilities.

At Greentree Shelter, Howard's case manager challenged him to work harder on his recovery from alcoholism, and he began attending AA meetings regularly. In addition, he was encouraged to search for employment, develop a budget, and apply for transitional housing where he and his children could live once they had completed their time at the shelter successfully.

In addition to helping parents find work, plan for the future, and continue their recovery from substance abuse or domestic violence, the Greentree Shelter staff concentrate on helping them develop their parenting skills. Every family entering the shelter has an initial meeting with a parent educator and can choose to continue meeting regularly. Parents also must participate in an active parenting program, which meets for two hours every week. The meetings begin with a dinner, at which families make a wish over a lit males and females on sexuality, sexual assault, and assertiveness training. Male staff act as positive role models. In that program, the children's coordinator meets individually with children to help improve communications between children and their parents in preparation for the transition to independent living.

Many programs use peer groups and special curricula to foster children's self-esteem, as well as their socialization

candle. "We're trying to show families how important rituals are," says the assistant director. "Candles add to the festivity. The kids just love it because it's serious, yet playful, and very predictable."

After the meal, the parents form one group with the parent educator, while the children split into three groups according to age. The adults discuss their own childhoods, contrasting their experiences with those they hope to give their own children. Parents learn about what their children need at each stage of development to help them achieve their potential. The Greentree Shelter staff say that parents gradually change the ways they relate to their children, and often a new playfulness emerges as parents' stress levels diminish.

In Howard's case, his defensiveness decreased over the course of several months. He came to trust the parent educator, who helped him open up communication with his children. His parenting became more supportive. For the first time, he was able to acknowledge his children's awareness of his addiction and allow them to share his recovery process.

Greentree Shelter staff also invest time and energy in helping children recover from the trauma of homelessness and keep up with school work. The staff have close ties with the neighborhood elementary school, meeting regularly with teachers to help ease children's transition to new classrooms in the middle of the school year. At the same time, the school's parent teacher association (PTA) reaches out to the parents. Because the children are often behind in their studies, Greentree Shelter provides tutors for the children twice a week.

Families typically stay at the shelter between three and five months. Eighteen to 24 months of transitional housing is available on a competitive basis to clients who show the most commitment to continue with their service plans. While they live in transitional housing, their names are likely to come to the top of the waiting list for public housing, ensuring the families permanent, affordable housing for the future.

After three months at the shelter, Howard got his old job back and moved with his children into transitional housing, away from his old friends. People who come to Greentree Shelter have little self-esteem, says the assistant director, and "low self-esteem brings low-quality friendships." As residents begin to feel better about themselves, they want more for themselves and their children.

Although Greentree Shelter has no formal aftercare program, staff help families learn how to use community services and urge them to stay in touch with shelter staff. The staff is now working to develop more resources for graduates, including a network, a newsletter, and an increased number of reunions.

Persistent poverty remains a huge challenge in aiding the transformation of the families who come to Greentree Shelter. Even when many of the underlying family issues are being addressed, "It's very difficult for these families to become self-sufficient on the incomes they're earning," says the assistant director. If she could have one wish, she says, it would be to gain new funding to allow Greentree Shelter to develop a comprehensive employment program. Such a program would give residents on-the-job work experience to enhance their chances of finding and keeping jobs with living wages. That, in turn, would give them and their children greater assurance of a secure future.

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and conflict resolution skills. Through daily, facilitated peer group sessions, counselors help children develop the sense of self-worth that will enable them to weather their families' difficult times and fortify them against vulnerability to abuse. The **Exodus** substance abuse program in Compton, Calif., runs a "Heroes and Sheroes" program for the school-age children in the program, many of whom had been holding the family together before the mothers got into treatment. The program uses culturally based self-awareness exercises, tutoring, recreation, and mentoring, to help the children recognize the hero or shero within themselves.

At the **PAR Village** substance abuse program in Largo, Fla., staff complete an educational development plan for each child and work with teachers to ensure that the children's individual emotional, social, and cognitive needs are addressed. Many of the programs surveyed worked closely with the teachers at the schools where children attend. Some, like **Greentree Shelter** in Bethesda, Md., also offer extra tutoring. (See box on pages 28–29.)

Offering Preventive Health Care and Recreation

Family care programs identify and address children's health needs, many of which have been neglected. They routinely administer speech and hearing screenings and immunizations, as well as other basic preventive care. Some also offer periodic well-baby clinics on-site. A number of programs have resident nurses or visiting doctors. Some programs have an after-school program for older children, featuring on-site computer rooms, recreation activities, and homework help. Other programs operate summer day camps on-site. These give children opportunities to develop skills and have fun. **Warren Village**, a program for homeless families in Denver, has a community garden for children to tend in the summer.

Recreational therapy is part of the curriculum of many family care programs because as a **Warren Village** staff member explains, "a lot of parents just do not know what to do when they're alone with their kids, besides discipline and feeding." Family field trips to zoos, outdoor concerts, and athletic games give children and parents a chance to enjoy new experiences together.

By serving both parents and children as separate individuals with separate needs and, at the same time, strengthening the parent–child relationship, family care aims to heal two generations simultaneously, thus breaking cyclical patterns of family dysfuntion, substance abuse, and domestic violence.

Preparing Families to Leave Family Care

Although family care programs typically establish general treatment timetables, most of the programs we surveyed try to be flexible about the timing of each family's departure. The parent and her counselor or treatment team generally make the decision together, within the parameters established by each program's funders. (The advent of managed care, however, will likely lead to more restricted and rigid treatment schedules.)

At the time of our survey, the typical length of stay for families participating in domestic violence programs was nearly three months; in substance abuse programs, it was about eight months; in programs for pregnant and parenting teenagers, the average was 13 months; and in family care programs for homeless families, many of which were considered transitional housing programs, the average length of stay was 22 months.

Since family care programs are usually voluntary, participants may leave without completing the program. As we noted earlier, women are most likely to drop out during their first month in residence, when the routine is new and the challenges seem the most daunting. Program staff report that women who leave prematurely often have been pressured by a spouse or partner to do so, especially if the partner is a substance abuser. The staff say women are vulnerable to this pressure because they are uncertain about their ability to make it on their own. At New York's **Casa Rita**, for families facing substance abuse, the women attend a group called "Mr. Wonderful" to help them confront this issue.

Some programs ask clients to meet certain requirements before leaving the program. **Flowering Tree**, in Pine Ridge, S.D., for example, requires all women without a high school diploma to complete their GED. In addition, each mother in the substance abuse program must be attending all meetings and special events at her child's school. At **Flint Odyssey House, Inc.**, another substance abuse program in Flint, Mich., each woman preparing to leave must develop and orally present to her peers a five-year plan outlining how she plans to support herself financially and socially.

In many family care programs, decisions about discharge are based on the child's needs as well as the mother's. At **Women's Residential Services**, in Libertyville, Ill., discharge from the substance abuse program is often planned to coincide with the end of the semester or school year, so children's lives are disrupted as little as possible. According to staff members in several programs, children often regress a little prior to leaving the program, a symptom of their fearfulness about leaving a safe environment.

Like their children, the women also have "a lot of anxiety as they leave the structured program and go to live on their own," says a staff member at **Casa Rita**. To help clients deal with their uncertainty, some programs offer pre-discharge groups, where the women can discuss their concerns and expectations about living on their own. A number of programs bring in their graduates to talk about their lives in the "real world."

Offering Transitional Housing

Program staff say that clients' gains during residential treatment are more likely to come undone if they return to the same type of living situation they were in before they entered care. Yet that is often the only housing the graduates can afford. The director of **Casa Rita** says, "The lack of affordable housing on the exit end scares the residents to death. They do so well here, and then they have to face moving down in safety and up in cost."

The problem of housing is especially acute for teen parents, says a staff member at **Seton Home** in San Antonio, which recently began providing two years of transitional housing to give their teen parents a safe place to live while completing school and preparing for a job or college. At 16 or 17, these teens cannot legally live on their own, she explains, but foster homes that accept young mothers and their babies are extremely difficult to find. As a result, many who are wards of the state must either remain in a program they have outgrown or return to the same circumstances they were living in when they got pregnant.

A staff member at **Crittenton Programs, Inc.**, in Wheeling, W. Va., says that her program's 18-year-old graduates face the same problem. She notes the inconsistency of expecting wards of the state, who often have histories of severe abuse and neglect, to be independent at 18, when nationally the average age for full emancipation from parents is more like 26. "Without an appropriate transition," she says, "we're seeing the independent living kids failing."

To better meet client needs for housing and extended services, more and more family care programs are trying to offer transitional housing after intensive treatment has been completed. **A New Life** in Philadelphia added transitional housing to its 90-day mentor home program, after finding that post-program housing was such a worry for clients that they were not completing substance abuse treatment. At the time of our survey, just less than half of the programs offered transitional housing.

Providing Aftercare and Permanent Housing

A staff member at **ABC–Rosie & Harry's Place** for homeless families in New York says she believes that women leaving her program have a slight advantage in the housing market because graduates have established a positive track record with the landlord of the program's transitional housing. Yet finding safe, affordable housing is a huge hurdle for most family care graduates. Consequently, many programs employ a housing specialist to aid clients in the search for a permanent place to live.

A few programs serving homeless families even offer services to help women buy their own homes. **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., for example, helps clients set up voluntary home savings accounts and matches clients' deposits, up to $500 a year. In Kentucky, the Lexington Board of Realtors Community Housing Foundation offers workshops for parents at **Virginia Place** on how to obtain home loans and purchase a home. The foundation itself offers low-interest home loans and helps pay closing costs for program participants.

Many family care programs have established rituals to help their new program graduates, other clients, and staff members acknowledge and celebrate a family's transition to independent living. **Women's Residential Services**, for example, holds a group meeting to say goodbye to each woman leaving the program. The departing client sits facing the wall while the others take

Exodus

"Making a lifetime commitment to our families."

Before the birth of her fifth child, "Angela" says she was on a self-described "death mission." She worked as a prostitute to support her drug habit. One by one she had lost custody of her four older children, all of whom were being raised by an uncle. Each time a child was removed, she says, she had another.

But when Angela became pregnant with her fifth child, a convent took her in, and she decided to try to change her life. She began to look for help, but the search was difficult because she was determined to keep her baby with her. The programs she knew about, she says, "would lock you down in treatment, but then send you off on your own as soon as it ended. They wouldn't help you. They didn't have time."

Fortunately, Angela eventually found Exodus, one of 15 programs that comprise the SHIELDS for Families Project in South Central Los Angeles. SHIELDS provides comprehensive community-based services of varying intensity to families who are affected by substance abuse.

SHIELDS began operating in 1987, at a time when about 1,200 infants were being born substance-exposed every year at the Martin Luther King Hospital. The program's goal was to help the mothers get off drugs, stabilize their lives, and strengthen their parenting skills so they could provide a nurturing family life for their children. Since its beginning, more than 3,000 families have participated in SHIELDS' programs, with about 80 percent achieving drug-free lives. Exodus, the first SHIELDS program to combine housing and treatment, opened in 1993 with funding from the federal Center for Substance Abuse Treatment.

Exodus serves women who are pregnant or have a child younger than age 1, have a long history of substance abuse, and are at risk of homelessness. The program houses 50 families in individual apartments in the Keith Village apartment complex in close-by Compton, Calif. Three staff members live on-site. The staff decided that since the program's goal is to empower parents to live on their own and care for themselves and their children, it made sense to give families their own apartments and help them learn to manage their responsibilities as they move through treatment.

In addition to their infants, mothers also may bring their older children to live with them. The family may be joined by others the mother considers family members, if those individuals are willing to respect the program's insistence on a clean and sober lifestyle. Residents pay rent based on a sliding fee scale and are responsible for their own utilities, phone service, and other expenses. Mothers have lunch together each day but prepare other meals in their own apartments.

The Exodus program staff includes a substance abuse specialist, a clinical psychologist, a child psychologist, and—because about 80 percent of the mothers were sexually abused as children—professionals who deal with sexual and other forms of abuse. For the mothers, Exodus offers an intensive day treatment program on-site, six hours each day, six days a week. All of the mothers receive psychological testing, and all children get extensive developmental and psychological testing. Every family is assigned a counselor, a case manager, and a child development specialist, all of whom work as a team with the family.

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turns saying the things they wish they had said to her. A staff member says a woman might typically say, "I never told Pam that I really learned a lot from her, and I wish I could have told her how much I care." The departing client then uses the same format to tell her peers what she has been unable to say to them. It helps all of the clients acknowledge separation issues, promotes closure in peer relationships, and teaches appropriate ways of expressing grief and accepting loss, says the staff member.

When they actually start life on their own, program

Parents participate in job training, GED preparation, and other education services that are located at other SHIELDS sites, and Exodus residents also may receive on-the-job training in the program's food services operation and its health and fitness center. For young children, Exodus has a child development center and therapeutic nursery, and for older children, an after-school and Saturday program called "Heroes and Sheroes." Children between ages 5 and 14 are picked up after school so they can participate in the program while their mothers are in treatment. Exodus staff also keep in close touch with the children's teachers.

Participants in Exodus have a voice in the program through a family council. Many special programs—including grief and loss groups, sexual abuse programs, domestic violence groups, a "significant others" group, and parents' involvement in the Heroes and Sheroes program—were added at parents' request through the council.

Participation in Exodus ranges from 10 months to two years, depending on the needs of the family, with the average stay lasting about 16 months. Among SHIELDS' greatest challenges, says a staff member, is providing adequate assistance to families coping with both mental health and substance abuse problems. Exodus staff say they are struggling to do a better job of meeting the special needs of the adolescents in the families they serve, who often feel hopeless and may engage in self-destructive behavior.

Exodus is unique in that it offers families lifetime aftercare services. Mothers who finish the treatment program do not have to move out of their apartments. They begin to pay more rent, but the family can continue living in an environment that supports a clean and sober lifestyle. While parents work toward their education and training goals and find jobs, they can maintain the relationships they have established with schools and other services in the community. Their children can continue attending the child development program and other special activities at Exodus. As one staff member explains, this arrangement "allows the families to test out life while still in a safe environment."

Eventually, changes in the families' lives lead them to move to other housing. Even when they are on their own, families can return for counseling, crisis intervention, even outpatient treatment, when needed. SHIELDS recently purchased a rental housing complex for its graduates because it is so difficult for families to find affordable housing in neighborhoods that support a clean and sober lifestyle.

For Angela and her youngest child, the future looks promising. After a great deal of hard work, Angela has been clean now for two years. She says that the staff at Exodus helped her "understand when you relapse why you relapse. They help you get to the things that you have been covering up, things you did not even know about yourself. I know myself now." Angela also has become reacquainted with her other children, and it is possible that one or more of them may live with her someday. Meanwhile, she now has her extended family back for herself and her youngest child. She is taking her new life one step at a time and learning to be the best parent possible.

As one of Angela's peers puts it, trying to sum up the Exodus approach, "They love you until you love yourself."

graduates obviously face challenges related to income, employment, and social supports, as well as housing problems. Recovering addicts run a substantial risk of relapse upon discharge, say program staff. Former victims of domestic violence are at high risk of being harmed or even killed by their abusers just after discharge.

For these reasons, good aftercare is essential to help families make a successful transition to independent living. Most of the programs we surveyed offer some aftercare services, usually home visits and continuing access to at least some program services. All types of family care programs agreed that families find it difficult to maintain the radical gains made in their program without aftercare; often it was added as a component after finding that its lack of availability minimized the impact of the program. **New Empowerment Alternatives**, for teen parents in Trenton, N.J., is one of the programs in the midst of beefing up its aftercare. In the words of staff, "Our residents have been through some very traumatic experiences. We believe it's important to maintain some level of services after they leave as they are still a vulnerable population."

Families are likely to be isolated and to have few social supports when they first leave family care. Often graduates try to get a fresh start by moving to a new neighborhood, and some women are living on their own with their children for the first time. To help ease their feelings of isolation, programs typically urge former clients—even those who leave prematurely—to telephone, collect if necessary, when they need support.

Many programs also have a staff member call or visit the family regularly. Some programs have a separate aftercare worker, and others allow the client to choose her contact person from among the staff. In areas where public transportation is not accessible, programs may make staff available to drive former clients to medical appointments and to take care of emergencies.

At **HerStory House** in Rutland, Vt., staff visit families who had experienced domestic violence as often as five times a week, sometimes after school, to talk with the children as well as the mothers. "Home visiting generally ceases after six months," says the director, "although the visits may continue longer—until they do not need us anymore and can stand on their own with friends and networks they've established at their new home."

Many programs offer aftercare support groups as part of aftercare. Former residents can continue to meet and discuss the challenges of independent living. In programs such as **Flowering Tree** and **HerStory House**, graduates also are welcome to participate in all of the program's regular services on an outpatient basis. Frequently **HerStory House** graduates come back to have lunch and socialize, says the director. Other programs, including **Hutchinson Place** serving families struggling with substance abuse in Philadelphia, find community volunteers to serve as mentors to program graduates and help them get established in the community.

"We have come to realize," says the **HerStory House** director, "that we cannot expect women to be safe on a long-term basis if we do not give them other supports to stay out of a bad relationship. There she is in a new apartment with no furniture and children all over, and her batterer stops by, inviting the family out for pizza. It's very tempting to go back."

Many programs extend aftercare to children, to give them an anchor of stability while they adjust to their new life. **Families in Transition**, a substance abuse program in Miami, is one of a number of programs that allow children to remain in the child care program after discharge. Children can remain as long as their mothers agree to volunteer at the child care center for a specified number of hours each week. At the time of our survey, the program director said the policy was especially helpful because there was a three-to-five-year waiting list for subsidized child care in Miami.

Sometimes the ongoing connections are informal and family to family. The director of the **Middle Way House** in Bloomington, Ind., recalls two families who moved in together when they graduated because it was the only way they could escape their abusive partners and afford rent. With help from skills learned at the program, the two mothers now own a business together. Staff at **St. Martin's House** in Washington, D.C., describe being invited to birthday parties for children of graduates from the substance abuse program and often finding several former residents present with their children.

Exodus, a substance abuse treatment program in Compton, Calif., appears to provide the most extensive aftercare services among the programs we surveyed. It not only provides transitional housing, but lifetime aftercare services that include support groups, individual counseling, vocational and educational classes, and job placement. (See box on pages 32–33.)

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Chapter 3

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WHAT MAKES FAMILY CARE PROGRAMS EFFECTIVE

We undertook our survey of family care programs to learn more about how these programs work and to identify their unique characteristics. We discovered many differences among the 50 programs we surveyed and among those serving different populations—indeed, we tried to identify those differences during our interviews. At the same time, we wanted to determine what common elements at the core of these programs make them unique, regardless of whether they serve families coping with substance abuse, domestic violence, homelessness, or teen pregnancy and parenting. Several of the elements these programs share appear to be critical to their effectiveness in supporting and stabilizing highly stressed families who are committed to addressing the challenges they face and beginning the healing process. We briefly review those below.

Comprehensive Services

Family care programs are distinguished by their holistic approach to serving families. Although the family care programs we surveyed generally identify themselves as serving victims of domestic violence, homeless families, families recovering from substance abuse, or pregnant or parenting teens, program staff recognize that many of the families they serve are coping with several of these problems simultaneously. As a result, more and more programs are reaching beyond their original missions in order to serve the complex needs of the families in their care. All of the programs we surveyed, for example, help families find housing. Most of the programs offer some kind of therapy for victims of sexual abuse or domestic violence, and the majority offer assessments for substance abuse, if not other services related to substance abuse. (See Appendix D for summaries of the services offered by each family care program we studied.)

Services for women in family care address their roles as women, mothers, and members of the community. At the same time, children's needs are recognized and specifically addressed. In some programs, children's services beyond child care have been slow to develop; in others, services for children are nearly as extensive as those for parents. One of the unique elements of family care is the opportunity for daily supervised interaction between parents and their children. In many programs, parents not only provide routine care for their children under the supervision of trained staff, they also participate in guided play sessions and family therapy.

Many programs also reach out to other family members. About three-quarters of those we surveyed offer either a men's group for their clients' partners, or for other family members who are not in the program.

A number of program providers say that their ability to retain families is directly related to the broad scope of services they offer. Several report adding services periodically to address the service gaps that appear to contribute to families' premature departures. **Exodus**, a substance abuse program in Compton, Calif., for example, added treatment for domestic violence and sexual abuse at the urging of its family council, a residents' advisory body that regularly advises staff. **Exodus** has even started a service program for parents who drop out of treatment, many of whom eventually return to treatment. **A New Life**, a substance program in Philadelphia, added a transitional housing program when it found that mothers were leaving the 90-day treatment program early, fearing they would not find housing if they waited until the end of the program.

The residential nature of family care programs means that services are intensive as well as comprehensive. Staff are always available to reinforce the messages participants receive during classes and other treatment activities. They also are able to assess how families are responding to services and make mid-course corrections when necessary, unlike traditional service providers who must wait until the next scheduled appointment.

Attention to Children's Safety

Family care programs use multiple strategies to assure the safety of children in residence. Some of the treatment programs serving parents with substance abuse problems do not allow children to join their mothers in residence until the parent has completed the initial—and often the most difficult—phase of treatment, usually after about 30 days. Staff say this rule helps make sure the parent is committed to treatment and is likely to remain. In other programs, such as **Exodus**, women are not allowed to leave the program unescorted during this initial period.

In residential programs like these, the intensive involvement between family care staff and participating families also provides an important check on child safety. At nearly every family care program we surveyed, at least one staff member is on-site 24 hours a day or is available by pager. The highly structured programs leave the women little unsupervised time and bring them and their children under constant staff scrutiny. In fact, women at **A New Life** in Philadelphia report that during the early phases of their recovery program, staff are "always in our faces." When parents act inappropriately toward their children, staff are able to intervene immediately and encourage more appropriate behavior. Because family care programs generally provide on-site child care, staff have ample opportunities to monitor the children's well-being and development.

The presence of other parents in residence provides another safeguard for children in family care. When one parent's conduct puts a child at risk, another parent is likely to intervene. Other parents also are able to offer respite to a parent temporarily overwhelmed by child care responsibilities.

Like other providers of services to children, the staffs of residential programs are mandated by state laws to report suspected abuse or neglect to the appropriate authorities. Family care programs serving parents already under the supervision of child protection services also must work with the agency to make sure appropriate safety plans are developed for children who reunite with their families.

Some mothers who participate in family care decide voluntarily to relinquish custody of a child. The ability of a parent to observe staff assisting their children, or other parents interacting with their own children, may help a parent, wavering about continued parenting, decide that she cannot parent. When that happens, or when the state acts to remove a child from a parent, the family care program can serve as a safe place for the child during the transition and offer help to the parent.

Commitment to Longer Treatment Timelines and Family Healing

Family care providers recognize that women typically enter their programs after lifetimes of crises. It is not unusual for a client to have been a victim of sexual abuse as a child, to have become pregnant as a teenager, to have been a victim of domestic violence, to be addicted to drugs or alcohol, and to be a homeless single parent with few job skills. Family care staff have learned that it takes a lot of time and help before the many wounds created by such experiences can begin to heal. As a result, most family care programs have become more flexible about the duration of treatment.

The director of **Middle Way House** for domestic violence victims in Bloomington, Ind., for example, says that her staff discovered that its original 30-day residence limit, combined with the city's lack of affordable housing (there was a 2,000-name waiting list for subsidized housing) was driving women back to the homes of their abusers. The program responded by increasing the length of stay to 60 days, then to 90 days, then started making decisions on a case-by-case basis. Whereas 50 percent to 65 percent of the program's clients returned to their abusers under the strict time limits, she estimates only 7 percent to 18 percent do so under the current flexible system. The Village in Miami also measured the impact of additional time in care as part of its study of drug use by parents at a follow-up. The study found that as length of stay at the **Families in Transition** program increased, drug use at follow-up decreased.

Data like these and the experiences of the families served resulted in virtually all of the family care providers we interviewed describing the importance of transitional services for families once they have completed formal treatment. They note that despite their extended treatment timelines and the 24-hour availability of service, the transition to self-sufficiency poses serious hazards to the fragile gains achieved in family care.

By extending aftercare to families just beginning to live on their own, family care programs help women maintain their hard-won gains and resist the pressures to fall back into familiar destructive patterns and relationships.

Three-quarters of the family care programs we surveyed offer program graduates continued access to services. Two-thirds of the programs also regularly stay in touch with program graduates by phone or through visits by an aftercare worker. Some programs plan special opportunities for families to return to the program for peer support. Others let parents continue their children in child care at the family care program.

Nearly half of the programs we surveyed have gone even further and have developed or are developing transitional housing to provide families an intermediate step between treatment and independence. Allowing families to test and gain confidence in their newly developed skills in a somewhat sheltered environment should increase their prospects of a successful transition to self-sufficiency and permanency, say program staff. "Initially," says the director of **First Step Home** in Cincinnati, "we had no intention of providing transitional housing, but then we realized what a high risk there is for relapse when low-income women return to low-income housing." The substance abuse program recently added two transitional housing programs to their aftercare services.

Some of the programs that offer transitional housing have developed their own units, which they run. Others have worked out a variety of arrangements with other community organizations that operate transitional housing.

An Accepting yet Demanding Service and Treatment Environment

The considerable demands placed on parents seeking to radically alter their lifestyles as they are recovering from substance abuse, domestic violence, or homelessness can periodically tax their coping mechanisms to the breaking point, resulting in temporary relapses and setbacks. Too often, traditional treatment and service programs respond punitively to these setbacks and offer their clients little help in understanding or recovering from them.

Although family care providers have clear expectations and standards that participants are expected to meet, program staff recognize that setbacks and relapses are a part of recovery. Family care aims to create an accepting environment in which participants can acknowledge their setbacks and use them to gain a better understanding of the challenges they face. Family care programs send the message: "If you're ready to work with us, we're here to work with you."

It is the delicate balance between structure and support that appears to make family care so effective for a highly vulnerable population. Many of the residents of family care programs already have been in and out of other treatment programs, and this may be their last chance. Although all of the programs we surveyed have rules against the use of alcohol and other drugs during residence in the program, the staffs are prepared for relapses. Many family care programs require mothers to develop plans to keep their children safe in the event of a relapse. If a woman does relapse while in treatment, she may be required to transfer to a short-term detox program from which she can re-enter family care, but she is not asked to leave family care altogether. Thus she has an opportunity to learn what triggers a relapse and how to prevent another. Sometimes children may remain in family care while mothers are in detox or, if the children must be placed with relatives or foster parents, they may continue attending the child care program for the sake of consistency and stability. Consequently, parents have a chance to work through relapses while keeping children safe, to learn from the experience, and to get on with their lives. Overall, they are better prepared for the future.

The importance of maintaining the delicate balance between nurturance and limit-setting was emphasized by many of the people we interviewed. Says the director of **Teen Parenting Services** in Portland, Maine, "Once they 'get it,' they can really make change. We roll with their testing [of us] and come out with some really wonderful family dynamics."

Similarly, the domestic violence programs we surveyed all are committed to helping their clients build new lives free of violence. Participants generally are not allowed to see their batterers while they are in the program. At the end of their stay, some clients decide to return to their batterers, most often if it is the first time they and their children have left home. However, the staff make clear their concern to the client and will call child protective services if they believe the children are in danger. The staff also urge the client to return if she needs help again, hoping that next time her leaving will be for good.

Staff Commitment and Skills

It is not surprising that most of the family care providers we interviewed attribute a large part of their program's effectiveness to their dedicated and tireless staff. Several conveyed that a family care program is "only as good as its staff." Staff are central to healing.

Family care creates unique opportunities for families to develop strong relationships with staff that contribute to the families' progress in building new lives. Yet families in crisis place relentless demands on staff to be constantly available, accessible, and supportive. Therefore, staff face the daunting challenge of being responsive to parents without becoming depleted of their own emotional energy and enthusiasm. To meet this challenge, staff need to strike the right balance between dependence and independence for these families. They must be available but at the same time encourage families to cope with crises on their own.

In addition, staff must continually search for the right therapeutic balances as they work with parents and children to strengthen family bonds. For example, staff must be nonjudgmental, yet hold parents responsible for the decisions they make. Staff must be constantly vigilant to ensure children's safety and teach parents to better protect their children, yet must not unduly interfere in the parents' child-rearing prerogatives. Staff must nurture and guide the children in their care but must not allow parents to forfeit their parenting responsibilities.

Most family care directors say it is a challenge to find staff who can maintain this delicate and essential balance and doubly challenging to find staff who can address the needs of both troubled women and troubled children. Professionals with long experience in treating women with substance abuse problems, for example, generally have little experience in helping these women cope with their parenting responsibilities, and even less in working with their children. Consequently, some family care providers have developed their own training programs, and other have sought out expert staff to work with children as they have intensified their children's services.

Program directors generally say they rely on an initial orientation period to introduce new staff to the family care approach and then hold regular in-service trainings for ongoing skills-building and knowledge development for the whole staff. At **Teen Parenting Services**, staff develop new individualized staff training plans each year. Some programs attempt to reach out across agencies to find out more about available resources and to train others in the family care approach.

Active Peer Support

Finally, family care programs are designed to encourage clients to draw on their peers for support during and after treatment—another characteristic that contributes to the effectiveness of family care. The connections between staff and residents and among residents that comes with a residential, therapeutic community have many powerful benefits in moving the women forward together in their lives. "We're women of all different ages, we all have something to share, and the women really respond to that," says a staff member at **Flowering Tree**, a substance abuse program in Pine Ridge, S.D.

For many women, the shame associated with teen pregnancy, or victimization by a partner, or homelessness isolates them from their families and communities. Women who have been abusing alcohol and other drugs often have burned their bridges to family and friends. Having no support networks, many of these women have turned inward. Family care programs specifically address the isolation the parents often experience and their fear of not being able to meet the challenges of recovery and child-rearing alone. The programs do so by giving their clients the opportunity to learn new and constructive ways of relating to others in a family environment.

Peer support groups are used to encourage mothers to persevere in their own treatment and to help them explore parenting issues and children's safety issues. They also give the participants hands-on experience in relating to one another. For some women it is their first chance to develop a relationship free of manipulation. Family care programs also encourage peer support in other ways. Most require women to share responsibility for household chores such as cooking and cleaning. Some expect women to assist each other with child care, so that everyone can attend counseling sessions and other special engagements.

Interaction with and support from program participants continue even after families leave from family care. Parents who graduated from **St. Martin's House**, a substance abuse program in Washington, D.C., report that the bonds forged with peers during treatment and the friendships among their children remained a source of companionship, encouragement, and child care help when they began living on their own. In some cases, women consciously choose to move into neighborhoods where program graduates already live. In this way, women are able to build their own new communities, beginning with the relationships formed during their stays in family care.

Chapter 4

FAMILY CARE AND CHILD WELFARE

The safety and security of millions of American children may be jeopardized when their parents suffer from substance abuse, domestic violence, homelessness, mental illness, or are still children themselves. These are all problems that can make it extremely difficult for parents alone, without help from families, friends, or treatment specialists, to nurture and protect their children adequately. Many of these children then end up in the child welfare system, which is charged with making sure they are safe and well cared for until their parents can get help and resume their parental roles. Unfortunately, too few parents receive the critical help they need.

With most of its attention focused on the immediate task of protecting endangered children, the child welfare system typically does not assemble the full range of services and treatment required to address parents' complex needs, even though the majority of endangered children eventually return to their parents. There are notable exceptions, of course, but too often even when parents' problems are identified, treatment does not address underlying causes. Nor is there enough assistance available from substance abuse prevention and treatment, domestic violence, and housing agencies, and teen parent programs to help address families' needs more comprehensively. As a result, family crises erupt again and again, and children are denied both safety and permanence as they cycle in and out of foster care.

The Children's Defense Fund (CDF) initially decided to study family care programs in order to identify better approaches to addressing the needs of the most troubled families coming to the attention of child welfare agencies. We were familiar with current in-home strategies used to protect children and treat parents simultaneously. But some parents need more supervision and guidance than in-home services can provide. Others are homeless when they become involved with the child welfare system. We wondered if family care could be an alternative source of help for some families and how these programs balanced their attention to the needs of children and parents.

Our study has persuaded us that the best family care programs are able to provide short- and long-term protection for children by offering both them and their parents intensive services and support. Family care recognizes the impact of parents' problems on children and provides services that help mitigate the consequences. In addition, family care's comprehensive services for parents help them to build productive lives and create more stable, nurturing families. We must all work to find resources to make family care programs available to many more troubled families, both inside and outside the child welfare system.

At the same time, child welfare agencies should draw upon the example and expertise of family care programs and, in collaboration with other service agencies and community organizations, find new ways to offer troubled families the comprehensive help that will enable them to rebuild their lives.

In this section, we highlight three features of family care programs that seem critical to their success in helping to stabilize and heal families, but which too often are lacking in child welfare agencies. First, however, we briefly present data affirming that families served by child welfare agencies and family care programs struggle with the same kinds of problems. We also describe the types of interactions between child welfare agencies and family care programs that we learned about in the course of our survey.

Families Served by Child Welfare Agencies and Family Care Programs

In 1996, an estimated 3 million children were reported to child protective service agencies as abused or neglected. Almost 1 million of these children were determined by the agencies to be abused and neglected: 52 percent suffered neglect; 24 percent physical abuse; 12 percent sexual abuse; 6 percent emotional abuse; and 19 percent other types of maltreatment. About 25 percent of these children were under age 4.

Precise information about the families of abused and neglected children is scarce because until recently child welfare agencies have had only limited capacity to assess or track families' needs. Although there are some notable exceptions, current data on families are mostly from small studies or are anecdotal. Yet, in general, we know that both child welfare agencies and family care programs typically serve families who live in neighborhoods plagued by high rates of poverty, unemployment, substance abuse, and violence.

Families with Substance Abuse Problems

Researchers at Children and Family Futures in Irvine, Calif., Sid Gardner and Nancy Young, who have analyzed the implications of alcohol and drug abuse for the child welfare system and examined local studies, estimate that between 40 percent and 80 percent of the families in the child welfare system have problems with alcohol or other drugs. According to the National Committee to Prevent Child Abuse, in 1996, nearly 80 percent of the states reported that parental substance abuse is one of two major problems facing families reported for child maltreatment. Such findings are not surprising given that an estimated 12.9 million children live with an adult who has reportedly used illicit drugs in the past year, and there are an estimated 6.6 million children with at least one parent who is an alcoholic.

A 1998 study by the Child Welfare League of America (CWLA) found that while just over two-thirds of parents involved with the child welfare system need substance abuse treatment, available data indicate that existing treatment programs can meet less than one-third of the need. Children from families with substance abuse problems are believed to be overrepresented in out-of-home care, although few states track such data regularly. Gardner and Young reported that Washington state had done tracking and that 41 percent of infants placed in foster care in 1995 were born to mothers who abused alcohol or other drugs during pregnancy.

Substance abuse is believed by many to be at least partly responsible for the growing number of very young children in foster care. As the crack cocaine epidemic spread in the mid-1980s, the proportion of infants entering foster care grew quickly. By the early 1990s, almost one in every four children placed in foster care in California, Illinois, Michigan, Missouri, New York, and Texas (which together account for about half of the children in foster care) entered care before their first birthdays. Newborns made up the largest share of these infants. This pattern has persisted. The 1997 Multistate Foster Care Data Archive's examination of foster care placement patterns in these states reported that more than three times as many children under age 1 enter care as do children at age 1, and these infants remain in care about one-third longer than children in any other age group. In Los Angeles County, New York, and Philadelphia County, an estimated 78 percent of young foster children whose cases were reviewed in 1991 had at least one parent who was abusing alcohol or other drugs, according to a 1994 General Accounting Office (GAO) report. This compares with 52 percent five years earlier.

Children of parents with substance abuse problems also tend to remain in the system longer. The National Black Child Development Institute studied Black children in foster care in five major U.S. cities a number of years ago and documented that children from non-drug-abusing households were returned to their parents almost twice as frequently as children from drug-abusing households. They also found that the adoption rate for children of drug-abusing parents 26 months after placement was only 9 percent. Problems have certainly intensified since that study was conducted.

In some states the growth of children in kinship care placements also is attributed to the growth in children exposed to drugs. CWLA's survey of child welfare agencies indicated that about 40 percent of the state agencies reported that they recruited foster care parents and kinship care providers specifically to care for children prenatally exposed to drugs.

Families Suffering from Domestic Violence

Research noting a high level of overlap between domestic violence and child abuse and neglect was reported in 1997 in an Urban Institute study looking at efforts by child welfare agencies to address domestic violence among families they serve. The Urban Institute reports that research shows that between 37 percent and 63 percent of abused women have children who are being abused or neglected and between 11 percent and 45 percent of children who are abused or neglected have a mother who is being abused. Estimates of the number of children who witness family violence are in the millions. Child welfare agencies' limited awareness of domestic violence has meant that its prevalence in child protection caseloads has been largely unknown. Many agencies neither routinely screen for domestic violence, nor train staff to recognize it, although this is changing.

The San Francisco-based Family Violence Prevention Fund has encouraged collaboration between child welfare agencies and domestic violence programs, citing clinical and research evidence that domestic violence permeates child protection services caseloads. It notes that in Massachusetts a review of the case records for 200 substantiated child abuse reports showed that more than 48 percent included mention of domestic violence. An earlier study of child fatalities by that state's Department of Social Services found that in 43 percent of the cases the mother identified herself as a victim of domestic violence. In Oregon, a similar review found evidence of domestic violence in 41 percent of the families in which there were critical injuries or a death as a result of child abuse or neglect. Peg Hess at the Columbia University School of Social Work and other researchers who have studied family reunification patterns in child welfare also have identified family violence as one of the factors that contributes to the re-entry of abused and neglected children into foster care. Other researchers have noted that the vicious cycle of domestic violence and substance abuse in the same families entangles both batterers and victims.

Families Who Are Homeless

Homelessness and other housing problems also bring children into the child welfare system. Public child welfare agencies nationally reported that on average more than one-fourth of the children entering foster care were affected by homelessness or inadequate housing or both, according to a 1995 survey of 42 state and 270 local child-serving agencies by the American Public Welfare Association (APWA) (now called the American Public Human Services Association). APWA also reported that about the same percentage was unable to return home from foster care because of homelessness or inadequate housing.

Other documentation comes from studies of single jurisdictions. In the Washington, D.C., metropolitan area, for example, detailed case record analyses of 800 children placed in foster care during the first half of 1992 revealed that homelessness or inadequate housing had contributed to the placement of one-quarter of the children; 48 percent were from families with annual incomes of less than $10,000. A survey in St. Louis revealed that two-thirds of the children whose families entered the child welfare system because of inadequate housing ended up in foster care for that reason.

Teen Parent Families

Data on child abuse and neglect rarely include the ages of the mothers involved or specify their ages at the birth of their first child, so it is difficult to track teen parents in the child welfare system. Research into teen pregnancy, however, has documented the special challenges that very young parents face. Although support may be available to a teen immediately after giving birth, it often does not continue, and this lack of support may leave the child at risk of abuse or neglect. Research shows that young children are especially vulnerable to abuse and neglect, but again data on the ages of their parents are not available.

Relationships Between Family Care Programs and Child Welfare Agencies

Although child welfare agencies and family care programs serve similar families, CDF's survey showed that the relationship between the two varies greatly. We found that staff in all the family care programs surveyed, like others who work with children in a professional capacity, are obligated to report suspected child abuse and neglect to designated child welfare agencies. Although family care staff suggest that there is seldom a need to do this, when it is necessary, staff members are able to explain to the parent why the report is being made and can facilitate helpful follow-up that will protect the child. Staff members also say that such a crisis in one family often provides a learning opportunity for other residents. In addition, program staff in all family care programs report occasionally working with child welfare agencies when mothers themselves decide they are not able to rear their children.

Generally, however, the interactions between the family care programs and child welfare agencies varied and can be described in three groups. First, a few family care programs we interviewed have little or no contact with child welfare agencies. Second, a larger number have some contact, often because they have clients with children in foster care. The third and largest group of programs receives direct referrals from child welfare agencies and, like those in the second group, work with them on reunification plans.

Family care programs in the first group tend to see themselves as preventive programs that help eliminate the need for child welfare agencies to intervene in their clients' lives. Parents who enroll in these programs do so voluntarily and may be required to have custody of their children in order to participate. **Bridgeway** in Lakewood, Colo., for example, is a program for pregnant or parenting teens who are not involved with the courts or child welfare agencies. Most teens who come to **Bridgeway** do so because they are homeless.

Some of these family care programs, especially those serving families suffering from domestic violence, are somewhat hostile to the child welfare system. Staff members in these programs say that the system often blames mothers victimized by domestic violence for failing to protect their children, rather than recognizing that these women need help too. The executive director of **Middle Way House** in Bloomington, Ind., criticizes child welfare agencies for requiring an abused mother to flee her home with her children or risk losing them, instead of requiring the abuser to leave. Staff members at other programs cite different problems: Victims of domestic violence may lose custody of their children to their batterers. Staff of programs for teen parents complain that child welfare agencies typically offer no help to a young parent until after she has abused her child.

The second group of family care programs identified in CDF's survey has ongoing contact with child welfare agencies because many of their clients have one or more children in foster care. These parents generally become involved in family care programs voluntarily, and program staff may subsequently help them advocate for reunification with their children who are in foster care, once they have begun treatment and stabilized their lives.

In the **Pregnant & Postpartum Women & Infants Program** serving families struggling with substance abuse in Chicago, about 60 percent of the women have children in foster care. At **Woodsong**, another substance abuse program in Thomasville, Ga., 70 percent of the parents have lost custody of their children at some time, and many are reunited with their children during the course of treatment. Many homeless parents and their children find their way to family care programs without child welfare agency intervention, although they may have had prior contact with the agency and may even have other children in state custody.

Family care programs in the third group are heavily involved with child welfare agencies. Some of them are reimbursed by the agencies for at least a portion of the care they provide to children. For example, some of the cost of children's care at **A New Life** for families with substance abuse problems in Philadelphia is paid for by the federal Promoting Safe and Stable Families Program (formerly the Family Preservation and Support Services Program). The **Family Sunshine Center** in Montgomery, Ala., was created as a result of the merger of two programs—one for abused children and the other for battered women.

Some family care programs serve mothers who themselves are in foster care and are placed in family care under contracts with the child welfare agency. At **Riel House** in Yakima, Wash., for example, young mothers who are wards of the state are placed in the substance abuse program with their babies. At the **Adolescent Mother–Baby Program** for teen parents and their children in Hyattsville, Md., such referrals account for about 60 percent of the families served.

Most of the family care programs serving families referred to them by child welfare agencies tend to be substance abuse programs. **Women's Residential Services** in Libertyville, Ill., is one such program. About 40 percent of their families are referred by child welfare agencies. **Women's Way** in Honolulu is another. "We've done a lot of education of CPS [Child Protective Services]. It wasn't always our friend," says the executive director of **Women's Way**. "We offer formal and informal training for staff to give them a better understanding of what treatment is and to show that people in recovery can be good parents."

Parents who are referred to family care programs by child welfare agencies, especially for substance abuse problems, realize that the program may be their last chance to achieve sobriety and retain or regain custody of their children before the state takes action to terminate their parental rights permanently. The director of **Women's Residential Services** says, "In many cases, parents are here because they want to keep their kids." Generally there is a presumption by both the child welfare agency and family care program in favor of reunification, but only if the parent successfully remains in treatment. Many parents in family care have been in treatment before, but seldom with their children and seldom in programs as comprehensive as family care.

At **Flowering Tree**, a substance abuse program in Pine Ridge, S.D., parents with children in foster care participate in the program for about six weeks without their children. If all goes well, the children then begin visiting on weekends, and later come to live with their parents at the site. "If we don't think a woman will stay," says a staff social worker, "we postpone the mother and child reunion until we're sure, so the child isn't pulled in and out." At both **PAR Village** in Largo, Fla., and **Comprehensive Treatment Services** in Newton, Kan., mothers with children in state custody are given a similar head start in the program to make sure they are committed to treatment.

At the **Rose McCarthy Family Residence** serving homeless families in New York, child welfare agency staff attend bi-weekly case conferences to discuss family reunification. The administrative director of the substance abuse program, **Flint Odyssey House, Inc.**, in Flint, Mich., says that she sometimes asks the child welfare agency to delay reunification because the mother is not ready: "We are biased toward the children. If we believe this client does not have the potential to parent, we will delay. We really want to reunify, but not at the expense of the child." In other cases, she says, it has become clear that a parent is able to care for just one or two children effectively and needs to relinquish custody of others. Some parents must maintain contact with the child welfare agency after graduation from family care because the agency retains legal custody of the child even though the mother has physical custody.

SHIELDS, the parent agency of **Exodus** in South Central Los Angeles, works with the Los Angeles County

Department of Children and Family Services to prevent the initial break-up of troubled families, many of whom have substance abuse problems. SHIELDS is the lead agency for the Compton SHIELDS Family Preservation Service Network, which collaborates with other community providers and the public agency to send a team into homes to offer intensive in-home counseling, parenting education, and drug treatment to parents who might otherwise lose custody of their children. The team also advocates for housing assistance and mental health treatment for these families.

What Child Welfare Agencies Can Learn from Family Care

Whether families are struggling to overcome substance abuse, domestic violence, homelessness, or the problems associated with teen pregnancy and parenting, family care offers

How Child Welfare Agencies Are Improving Services for Troubled Families

Help for Families with Substance Abuse Problems

- To expand treatment capacity, the Sacramento County, Calif., Alcohol and Other Drug Treatment Initiative is providing alcohol and other drug treatment services through its child welfare agency and other parts of the social services system. Staff members in the county's Department of Health and Human Services receive special training in identifying, assessing, and treating clients with drug and alcohol problems, as well as training in case management for such clients.

- Delaware has received permission from the Children's Bureau in the U.S. Department of Health and Human Services to use its federal foster care funds to hire substance abuse treatment specialists to assist child protection staff in assessing families and referring them for appropriate treatment.

- In Washington state, the Division of Alcohol and Substance Abuse and the Children's Administration, both within the Department of Social and Health Services, are working collaboratively to provide assessment, treatment, and child care for parents and their children referred by the child welfare agency. Staff training is done across agencies and alcohol and drug abuse counselors are placed in some child welfare programs.

- Some Colorado counties have sought to pursue permanence more quickly for children under age 6 as part of the state's Expedited Permanency Planning program. Some of these counties have developed their own funding slots for substance abuse treatment and work to ensure that families get help the first week after placement. They also have reduced caseloads and undertaken concurrent planning. By six months, they have enough information to determine the possibility of reunification, and, if it is not possible, to accelerate plans for termination of parental rights and adoption.

Help for Families Suffering from Domestic Violence

- Massachusetts has established a Domestic Violence Protocol for Child Protective Services, and all Department of Social Services (DSS) staff are trained to recognize and respond appropriately to domestic violence in their caseloads. Domestic violence specialists with experience working with victims of domestic violence are hired by DSS to provide consultation in individual cases.

valuable assistance. Supervised residential settings, intensive therapeutic services, parenting education, peer support, services for children, and aftercare services all help keep children safe and move families toward long-term stability and self-sufficiency. Family care programs offer parents a fuller range of treatment for their own problems, as well as ongoing parent education and modeling to help them do a better job of meeting their children's needs. Family care staff typically help parents set goals for themselves and their children and map out a series of small achievable steps that will lead to the families' long-range goals. As a result, parents who complete family care programs have a realistic chance of retaining custody of their children and building new lives.

Unfortunately, the array of services generally offered by child welfare agencies often does not resemble that offered by the best family care programs. Although many child welfare staff say they would like to offer more help

- Oregon is in the process of training both child protection staff and domestic violence workers regarding the interaction between domestic violence and child abuse. On a pilot basis, the state also has contracted with advocates from domestic violence programs to help in some county child welfare offices.
- Michigan's Training Institute, established by the state's Family Independence Agency and Domestic Violence Prevention and Treatment Board, cross-trains domestic violence program staff and welfare, child protection, and family preservation service workers and supervisors. Some domestic violence service programs also offer referrals to Families First staff to assist battered women and their children.

Help for Homeless Families

- Child welfare and housing authorities in 16 states have jointly applied for and received Section 8 housing certificates under the Family Unification Program. These five-year certificates must be used for families whose children are at imminent risk of placement in foster care or delayed in returning from foster care because of homelessness or inadequate housing. In its first five years of funding, an estimated 8,000 families have been assisted. Broader collaborative efforts by these child welfare and housing agencies also have resulted in other kinds of new assistance for homeless families that will help stabilize them in their communities. Since October 1996, all 50 states have been eligible to apply for funding, but certificates are now limited to one year.
- In Arizona, child welfare funds to assist with housing costs are available to families whose children cannot return home from foster care because the family lacks adequate housing. The subsidies can go up to $300 per month and are available for six months. Estimated cost savings from the program for the period 1990–1996 were $1,378,394, as a result of 1,215 children in foster care being reunited with their families.

For information on these and other activities, see Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy.* Washington, DC: CWLA Press; Gardner, S. L., & Young, N. K. (1997). *Bridge Building: An Active Plan for State and County Efforts to Strengthen Links Between Child Welfare Services and Services for Alcohol and Other Drug Problems.* Irvine, CA: Child and Family Futures; Aron, L. Y., & Olson, K. K. (1997). *Efforts by Child Welfare Agencies to Address Domestic Violence: The Experiences of Five Communities.* Washington, DC: Urban Institute; Carter, J., & Schecter, S. (1997). *Child Abuse and Domestic Violence: Creating Community Partnerships for Safe Families: Suggested Components of an Effective Child Welfare Response to Domestic Violence.* San Francisco, CA: Family Violence Prevention Fund; and Rog, D. J., Gilbert-Mongelli, A. M., & Lundy, E. (1998). *The Family Unification Report: Final Evaluation Report.* Washington, DC: CWLA Press.

to parents, they are frustrated by the lack of resources and difficulties in connecting with agencies and other organizations with relevant expertise and services. They also would like to be able to provide more intensive services to children. Nonetheless, we encourage child welfare agencies to find ways to offer families services with some of the characteristics typical of family care programs. We highlight three areas in which child welfare agencies could, by collaborating with a broader group of service providers, adopt aspects of the family care model to further improve their own services for families and better protect children. A June 1998 report from CWLA, *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy*, by Nancy Young, Sid Gardner, and Kimberly Dennis, also outlines innovative practices for linking child welfare services and alcohol and other drug treatment. Other examples of how some agencies are working to improve services for families struggling with substance abuse, domestic violence, and homelessness are described in the box on pages 48–49.

Targeting Services and Treatment to Parents and Children

Although the staff of family care programs are trained to recognize the needs of both parent and child and pay attention to the interaction between them, the staff of child protection agencies are mandated to protect children and respond first to children's needs. Federal law requires that reasonable efforts be made to reunify families as long as it is consistent with the child's safety, but several studies of reunification services reveal only minimal attention to parents' needs. Yet it seems obvious that the future safety of most children reunited with their parents is closely linked to changes in their parents. In part, agencies' failures to address parents' needs may reflect a staff bias against those who appear to be engaging in behaviors considered self-destructive and threatening to their children's well-being. But it is more likely that child welfare caseworkers are not well trained to recognize and assess the needs of parents' with substance abuse and domestic violence problems and steer them toward appropriate help. Until fairly recently, for example, it was rare for caseworkers to get special training on domestic violence.

In any case, more attention must be given to identifying and assessing a parent's need for specialized services or treatment, its impact on the child, and the parent's ability to keep the child safe. Once needs are adequately identified, they must be matched with appropriate help. Delay in finding treatment, especially substance abuse treatment, can be devastating, in part because the threat of intervention by the child welfare agency and removal of the child can motivate parents to commit to treatment and begin to change. Investments in parents can also prevent additional births of drug-exposed children. (See box on page 52.)

Too frequently, the treatment the child welfare agency offers parents with substance abuse problems ends with detox. Mothers are expected to make it on their own after that. Seldom do parents get comprehensive treatment to help them understand and overcome the aspects of their backgrounds that make them vulnerable to substance abuse or other kinds of self-destructive behavior. For example, an estimated 30 percent to 70 percent of mothers with substance abuse problems have been victims of sexual abuse. If their early traumas go untreated, these women are more likely to relapse. Yet few child welfare agencies or traditional drug treatment programs offer sexual abuse treatment in conjunction with drug abuse treatment.

Similarly, the agency may rescue abused children from families where there has been domestic violence but may not consider the abused parent as a victim who also needs help and protection. And even in their work with homeless and inadequately housed families, child welfare agencies often do not have the staff or resources to connect parents with adequate housing-related services or a broader range of help to address the underlying causes of homelessness. APWA reported that just one-third of the state child welfare agencies responding to its 1995 survey had a formal state policy on providing housing-related services to families in danger of losing their children for lack of adequate housing. Just 22 percent of the agencies said their workers were given special training on housing issues. Although most agencies make referrals to public housing agencies or nonprofit programs, two-thirds or fewer provide help with housing searches or offer cash or vouchers for rent, utilities, security deposits, or repairs.

Even when a parent's problems are identified and the caseworker has helped her find comprehensive treatment with service providers and community organizations, the caseworker's efforts cannot be considered finished, as family care workers have discovered. As each woman progresses and her needs begin to change, her caseworker must be ready to phase in new services and treatments to help her begin to build a new way of life.

Strengthening Parenting Skills

Given other demands, the staff of child welfare agencies typically focus relatively little time and few resources on helping parents improve their parenting skills. Monthly, or even weekly, parent–child visits to the child welfare office give parents and children little opportunity to interact and caseworkers little chance to observe the relationship between mother and child or offer guidance. Mothers are often sent to parenting classes (from which children may be excluded), but it is unusual for them to have opportunities to learn from hands-on parenting supervision, mentoring, and support. Yet family care staff say adults who were not adequately nurtured as children often need mentoring and guidance to help them improve their own nurturing abilities.

In addition to strengthening their fragile parenting skills, parents face many additional challenges as they try to prepare for regaining custody of their children. The program director at the **Grace Hill** family care program in St. Louis says, "We have a population of women with no income, no housing, no education, plus an addiction, and they are expected to have it all together before they get their children back."

Without significant therapeutic help, without opportunities to strengthen their parenting skills, and without ongoing support, many parents whose children have previously been in foster care find it difficult to maintain their recovery, maintain appropriate housing, and consistently nurture and protect their children so as to retain custody. It is not unusual for a mother, who is released from treatment and has two or three children returned to her with no preparation, to be overcome once again by her addiction and overwhelmed by her parenting responsibilities. Such women are likely to relapse and to have their children removed a second or third time from their custody.

Enabling Follow-Through and Aftercare

Family healing takes time, and families heal at different rates. The flexible treatment timelines in family care programs acknowledge that it takes clients varying lengths of time to recover and prepare themselves to return to the community with their children. The task is so daunting that even some family care programs, especially those with relatively short treatment time limits, report difficulties in fully preparing families for independent living. The staff of shorter term programs for families with alcohol or other drug problems, for example, generally find that their graduates are less prepared to maintain the gains they have made than are graduates of longer term programs.

Many family care programs have developed extensive aftercare services to provide the ongoing encouragement and support that families need to succeed on their own. These services include regular telephone contact with graduates, home visits by aftercare workers, and invitations to attend social events at the program site and to participate in some treatment groups on an outpatient basis. In addition, having discovered that troubled families are generally isolated from friends and relatives, family care staff help parents prepare for living independently. They help develop networks of relatives and other family care graduates who can offer support and assist new graduates to navigate the challenges they inevitably face when they begin living independently.

Family care staff also help parents prepare safety plans for their children in the event of a crisis caused by the parent's relapse or contact with an abusive partner. If a mother relapses, an aftercare worker can help her understand the events that triggered it and develop a plan to avoid those situations in the future without endangering the children.

Making a Case for Investment in Both Parents' and Children's Needs

Richard Barth, then Director of the Child Welfare Research Center and National Abandoned Infants Assistance Resource Center at the University of California at Berkeley, testified before Congress in October 1997* about some of the risks created by the current status quo where children are removed at birth from their mothers who abuse alcohol and other drugs and placed in foster care, but little or no service is provided to their mothers. He emphasized the value of investing in family care programs to provide more intensive help to both parents and children. The risks he cited and some of the evidence he offered to support them are described below.

Child welfare programs that fail to address parental substance abuse and that focus exclusively on the child will not help prevent subsequent births of children born substance-exposed who may enter foster care.

- Sixty percent of a group of 1,576 newborns suspected of being cases involving substance abuse who were brought into foster care in 1995 in California already had at least one sibling in foster care. About 1,000 children had a total of 2,634 siblings in care and, in the cases of about 25 percent of the children, there were three or more siblings in foster care. Eighty-one percent of these siblings were children still in care or back in care. On average, the newborns had siblings in care for four and a half years.
- Barth and his associates projected that if only one-third of these nearly 1,000 mothers had successfully engaged in treatment upon the first birth and had no more drug-exposed births, a minimum of 4,000 foster care placement years would be avoided, at a savings of at least $40 million for the children alone.

Reunification services for children who are drug-involved must be supplemented with a broader array of strategies to minimize the forces that result in relapses, including residential treatment programs and shared family care for mothers and children.

- In California, 28 percent of the infants studied who went home from foster care in California returned within three years. While substance abuse by mothers at the time of placement was pervasive among all clients, it was far more present in the re-entry group and increased the odds of re-entry substantially. While these families received some post-reunification services, these were thought to be insufficient to counteract the elevated risk factors in these families.

*Barth, R. P. (1997, October 28). Substance Abuse and Child Welfare: Problems and Proposals. Testimony presented before the Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Unfortunately, heavy caseloads in most child welfare agencies create enormous pressure to dispose of cases quickly. Aftercare services are neither anticipated nor encouraged. To the contrary, expedited timelines in the 1997 Adoption and Safe Families Act for initiating termination of parental rights proceedings, a necessary precursor of adoption, put even more pressure on agencies to take prompt decisive action for children in care. The new law is intended to expedite permanent placements for the estimated 100,000 children in foster care who cannot safely return home but continue to wait for new permanent families—certainly a worthy goal. However, there are dangers that these expedited timelines will eclipse opportunities for the appropriate reunification of families, when children are not threatened with serious harm, the parents have ongoing relationships with their children and they are actively working toward reunification but cannot resume full-time parenting within the new timelines. In certain circumstances, states can make exceptions and not file termination of parental rights petitions, but the decision is in large part left to the public agency with custody of the child.

At its best, the Adoption and Safe Families Act will result in increased emphasis on permanence for all children, regardless of whether they are slated to return home, to be adopted, or to be placed in some other permanent setting. To appropriately protect and nurture their children over the long term and prevent their return to foster care, child welfare agencies must begin much earlier to offer parents of children who will return home the support they will need. The process should begin immediately when the children enter foster care and continue during the transition to reunification.

Currently, child welfare agencies are unlikely to provide the follow-up and aftercare so necessary for vulnerable families, unless they are collaborating with a family preservation or family care program. Neither staffing patterns nor funding allocations make it possible for caseworkers to look in on reunited families regularly and offer ongoing help in solving problems that develop. If a parent relapses or a family crisis occurs, child welfare staff are likely to respond by removing the child from the family once again. Such a response protects children in the short run, but the periodic disruptions take a toll on children's emotional and developmental health. Parents receive little or no help to prevent other relapses in the future, and as a result, the destructive cycle of family break-up and reunification continues.

We believe that child welfare agencies can significantly improve their services to troubled families by offering family care as an optional service to families for whom it is appropriate. In addition, these agencies should modify their own current practices to do more to meet parents' needs, provide families more comprehensive services that specifically include help with parenting and parent–child interaction, and offer significant aftercare services so that families can sustain their early gains in treatment and build on them.

Applying the lessons of family care is not a task for child welfare agencies alone. It will require concerted action by multiple partners across disciplines and department lines and within our communities. We are convinced, however, that such efforts will help heal families and offer children the safety and permanence that is critical to their long-term well-being.

Chapter 5

HOW FAMILY CARE PROGRAMS ARE FUNDED

Family care programs generally depend heavily on a patchwork of public funding for financial support, augmented by in-kind and cash contributions from individuals and institutions in the community. The vast majority of program staff we interviewed for this report say it is a never-ending challenge to maintain existing funding to ensure program stability, let alone developing additional funding sources for program improvements. The director of **Casa Rita**, a substance abuse program in New York, says, "The biggest problem is the budget—how to run a program when we are always worrying about funding. The client problems are small in comparison."

Program variations among the 50 programs we surveyed make it difficult to compare program budgets or generalize about them. Annual program budgets ranged from $15 million in one very large program serving more than 500 homeless families at four sites, to $80,000 annually in a largely volunteer-run program serving four teen parents and their children. Overall, two-thirds of the programs we surveyed had annual budgets of more than $600,000. (See Appendix D for individual program descriptions.)

Among programs serving families with substance abuse problems, annual budgets ranged from $355,000 to $1.8 million. In programs for victims of domestic violence, the range was $180,000 to $1.4 million, and in those targeted to teen parents it was $80,000 to $1.5 million. Budgets in programs for homeless families ranged from $480,000 to $2.5 million, excluding the Homes for the Homeless Program's $15 million budget mentioned above.

The catalog of funding challenges faced by family care programs is long and varied. Administrators say they must continuously track the availability of public funds and try to keep up with differing eligibility, reimbursement, and reporting requirements for programs within multiple domains. Demonstration grant programs may expire; funding for ongoing services may be cut, frozen at inadequate levels, or appropriated at levels that fail to keep up with inflation or increasing need. Indeed, nearly one-third of the program administrators interviewed for this report say that their program had experienced significant funding cutbacks in 1996 alone.

Many program staff report of difficulties in persuading funders of the importance of good quality comprehensive programming for families. It is especially difficult, they say, to find sufficient funding to meet children's needs. Funders willing to support substance abuse treatment services for women, for example, often are not interested in funding services for children. Family care staff say few funders understand that services such as child care and transportation are an important part of effective treatment for mothers. It is even harder to fund activities that focus on parent–child interaction, although this is central to family care treatment. Consequently, staff often must piece together numerous funding sources to provide comprehensive services to parents and children. Funding sources for the programs studied, as the box on pages 58–59 indicates, cut across a range of categorical programs that generally serve children and families in a variety of circumstances and settings and provide different types of services and treatment. We identified at least 66 different funding sources used by the programs.

Many program administrators say that the constant search for new funding is stressful for staff. "The only thing that gets me anywhere close to burn-out is funding," says the director of **Middle Way House**, a domestic violence program in Bloomington, Ind. "We've been getting cuts in old funding sources, and the private sector doesn't kick in like people say it will." The program coordinator of **Women's Residential Services**, a substance abuse program in Libertyville, Ill., notes that too often "our program changes relate to funding changes. They are not clinically driven."

Many administrators link high staff turnover to funding problems, since recruitment and retention are difficult with the low salaries that programs can afford. "You're asking staff to do a very difficult job, and you're not paying them very much to do it," says the assistant executive director of **New Empowerment Alternatives** in Trenton, N.J., a program for pregnant and parenting teens. "Our salaries are not adequate," says a director of another program for teen parents. "People come in, get experience, and leave. We have constant staff turnover."

Providers talk about the need for new, dependable funding sources that would allow them to address families' needs comprehensively. Some of the suggestions are familiar ones, including the diversion of funds from prison construction. "It is cheaper to treat families than to put them in jail," says a director of a substance abuse program. Others suggest that the tobacco and alcohol industries should be funding family care. One administrator notes that many communities have a regular budget line for animal shelters, but not for domestic violence shelters. At the very least, say some family care staff, family care programs should be exempted from utility charges. A number of program directors suggest that public agencies for substance abuse treatment, mental health treatment, domestic violence, and child welfare services should jointly fund family care programs to provide a full range of services to families.

Funding Sources

Funding for the different types of family care programs discussed in this report falls into three major categories:

- Grants from service and research demonstration programs.
- Support from established programs that provide ongoing funding to a particular target group or kind of service.
- Individual assistance from benefit or insurance programs.

In all three categories, the sources of the funds are generally federal, state, and local programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS) estimates that approximately two-thirds of all alcohol and other drug treatment nationwide is provided through the public system.

Approximately three-quarters of the family care programs we surveyed depended on public resources for at least 80 percent of their annual budgets in the year they were surveyed. Federal funds comprised at least 50 percent of the budgets of half of all of the programs; six programs were totally federally funded. Frequently federal funds are matched by state and/or local funds and administered through state or local public agencies. Family care program administrators say that success in obtaining public funds depends in large part on the size and sophistication of the program and the ability of staff to devote significant time and energy to seeking funds.

Although many program administrators speak of the need to look for stable long-term funding from nonpublic sources, few say they have had much success. Typically, family care programs receive only limited fiscal and in-kind contributions from parent organizations, businesses, religious organizations, foundations, educational institutions, and civic organizations. (See box on page 58–59.) The last section of this chapter describes how family care programs benefit from donations of time, expertise, gift items, and supplies. (See pages 65–68.)

Service and Research Demonstration Grants

Substance abuse and mental health

Responding to the significant increases in drug use by pregnant women and births of drug-exposed infants during the late 1980s and early 1990s, the federal government started several grant programs to fund demonstrations of improved treatment for drug-involved women and their children, two of them specifically to test the benefits of residential settings for women and children together.

In 1989 and 1990, the National Institute on Drug Abuse (NIDA) funded 20 five-year research projects to assist with the treatment of pregnant or postpartum women and their infants born drug-exposed. The "Perinatal-20" Program supported both residential and nonresidential models and programs for women and for mothers and their children.

The Demonstration for Pregnant and Postpartum Women and Their Infants also was created in 1989 by the Office of Substance Abuse Prevention in collaboration with the Maternal and Child Health Bureau, both in HHS. It focused on prevention, education, and treatment efforts, as well as health services, in a range of outpatient, inpatient, and residential settings. It emphasized maternal–child bonding and sought to improve the abilities of mothers to meet their children's developmental needs.

Shortly thereafter, Congress directed the Center for Substance Abuse Treatment (CSAT) to begin two initiatives to support comprehensive residential treatment services for women and children. The Demonstration Grant Program for Residential Treatment for Women and Their Children, launched in 1992, sought to demonstrate effective methods of delivering residential treatment to substance-abusing women who have children up to about age 10. The 11 grants initially awarded in 1992 targeted treatment to racial and ethnic minorities. Later grants were focused on other subgroups of women with substance abuse problems who are especially hard to serve. These included women who had been physically or sexually abused, were involved with or at risk of involvement with the child welfare system, were residents of public housing, or were homeless. A second CSAT grant program—Services Grant Program for Residential Treatment for Pregnant and Postpartum Women—funded programs in 1993 and 1995.

Each of the CSAT residential treatment programs must have a six- or 12-month residential component, incorporate a wide range of interventions, and offer aftercare services. One notable feature of both is that grant dollars need not be applied to a specific treatment modality or narrow category of services but can be used to fund a variety of activities and links to other community service providers. To encourage state and local investments in these initiatives, both programs require state or local matching funds (10 percent in each of the first two years and 25 percent in each of the remaining three years).

As of October 1, 1997, 65 active demonstrations were being funded under these two programs—25 by the program for pregnant and postpartum women and 40 by the program for women and their children. Fourteen of the family care programs we surveyed were among the 65.

Congress reduced funding for these residential treatment demonstration programs nationwide from $60 million to $32 million between Fiscal Years (FYs) 1995 and 1996, and some program activities had to be discontinued. Funds were partially restored for the next year, so funding was restored to about 14 projects, but no new projects were funded. In 1997, the Clinton Administration and Congress redirected the focus of its prevention and treatment activities away from service and treatment demonstrations and toward "knowledge development." Increased funding for residential treatment programs was no longer forthcoming. Even more worrisome to family care administrators, federal funding for these residential treatment demonstrations is scheduled to end in FY 2000, when the five-year funding cycle ends for the last of the programs. The prospect of an enormous shortfall in support looms over many family care programs unless states or localities or private

Funding and Other Resources Used by Family Care Programs

Federal Funding Sources

Substance Abuse Prevention and Treatment

Center for Substance Abuse Treatment Grants
- Residential Treatment for Pregnant and Postpartum Women
- Residential Treatment for Women and Their Children

Center for Substance Abuse Prevention Grants
Substance Abuse Block Grant/Women's Set Aside

Domestic Violence Prevention and Treatment

Family Violence Prevention and Services Program
Social Services Block Grant
Violence Against Women Act Programs

Housing and Homelessness Prevention

Community Development Block Grant
Emergency Shelter Grants Program
Federal Emergency Management Agency Grants
Federal Home Loan Banks
Low-Income Housing Tax Credits
Section 8 Single Room Occupancy
Section 8 Vouchers and Certificates
Shelter Plus Care Program
Supplemental Assistance for Facilities to Assist the Homeless
Supportive Housing Program

Health, Nutrition, and Education

Child and Adult Care Food Program
Healthy Start Initiative
HIV Grants
Maternal and Child Health Block Grant
McKinney Education of Homeless Children Program
National School Breakfast and Lunch Programs

Social Services

AmeriCorps
Child Abuse Prevention and Treatment Act Discretionary Program
Child Care and Development Block Grant (CCDBG)
Child Welfare Services Program
Family Preservation and Support Services Program (now called Promoting Safe and Stable Families Program)
Foster Grandparent Program
Social Services Block Grant
Volunteers in Service to America (VISTA)

Individual Assistance

Aid to Families with Dependent Children Program (AFDC) (replaced by Temporary Assistance for Needy Families)
Earned Income Tax Credit (EITC)
Emergency Assistance Program
Food Stamps
Job Training Partnership Act
Medicaid
Pell Grants
Special Supplemental Food Program for Women, Infants and Children (WIC)
Supplementary Security Income Program (SSI)

entities are willing to pick up these funding commitments—or the federal government extends its support.

Two of the family care programs in our survey, **Exodus** in Compton, Calif., and **Flint Odyssey House, Inc.**, in Flint, Mich., were benefiting from the Starting Early/Starting Smart Supplements first funded in 1995 by the federal Centers for Substance Abuse Prevention, Substance Abuse Treatment and Mental Health Services, all in SAMHSA in HHS, and the privately supported Casey Family Program. These grants target children from

State, County, and City Sources

Public Funding

- Adult probation agencies
- Child care agencies
- Children's services commissions
- Civil justice institutes
- Community colleges
- Community loan funds
- Departments of corrections
- Domestic violence and sexual assault enterprise zone tax credits
- Domestic violence coalitions
- Foster care agencies
- Homeless services
- Housing authorities
- Mental health services
- Offices of prosecution services
- Prison systems
- Public health agencies
- Social services agencies
- Substance abuse prevention and treatment/chemical dependency services
- Tax check-offs/licensure fees for domestic violence programs

Private Funding

- Bridges to the Community Program
- Businesses
- Community donations/individual gifts
- Fees for service
- Foundations
- Fundraising events
- Religious organizations
- United Way (or similar entities)

Volunteers and In-Kind Contributions

- Accountants in the Public Interest
- Barbers/beauticians
- Big Brothers/Big Sisters
- Churches
- City Year
- Civic clubs (gardening, homemakers, auxiliary, etc.)
- College and university students/practicum students
- Computer Volunteers of America
- Community Work Experience Program participants
- Food banks
- Girl Scout/Boy Scout troops
- High school service clubs or community service
- Hospitals
- Junior Leagues
- Lawyers/legal services
- March of Dimes volunteers
- Medical alliances/associations
- Previous family care clients
- Pro bono counselors
- Restaurants and hotels
- Retired school teachers and physicians
- Senior citizens
- Sororities/fraternities
- Stores, car dealers, and printing businesses
- Summer youth employment program participants
- Teachers
- Toy manufacturers
- Universities
- Women in Construction
- Work release volunteers from public agencies, businesses, or corporations

birth to age 7 already in SAMHSA-funded programs for parents and/or children with substance abuse or mental health problems. They intend to examine the effectiveness for young children and their families of integrating mental health and substance abuse prevention and treatment services with primary health care services and early childhood services. **Flint Odyssey House, Inc.**, is using the funds to establish a new children's program, and **Exodus** is developing a comprehensive intake and assessment component for its children's program. At the same time, CSAT also offered funding supplements for child care services to its current grantees who were providers of substance abuse treatment.

Several family care programs we surveyed also were supported by demonstration programs focused on the special mental health needs of parents and/or children. **Integrated Family Treatment Program**, a substance abuse program in San Antonio, for example, received grants from the federal Community Support Program, the Child and Adolescent Services System Program, and the Child Mental Health Services Grant Program, which seek to enhance coordination and services for adults or children with serious emotional problems.

Family care programs also have received money from the federal Healthy Start demonstration program, an initiative designed to reduce infant mortality in communities with average infant mortality rates of 15.7 percent or higher. In fact, the Residential Treatment for Pregnant and Postpartum Women program gave priority to grant applicants located in communities with Healthy Start projects because substance abuse has been recognized as a major contributor to infant mortality. Some programs also benefit from the Abandoned Infants Assistance Program.

Domestic violence

Major sources of support for family care programs serving victims of domestic violence and homeless families include the federal Family Violence Prevention and Services Program, which helps fund a number of programs we surveyed, including **Women Helping Battered Women** in Burlington, Vt.

Grant programs under the 1994 federal Violence Against Women Act contribute to the budget of programs such as **Domestic Abuse Family Shelter** in Laurel, Miss. State programs for homeless families and victims of domestic violence help fund programs such as **Rainbow House** in Chicago, which receives some funding from the Illinois Department of Public Aid. Several of the programs we surveyed, including **Family Sunshine Center** in Montgomery, Ala., also receive limited assistance from state trust funds for victims of domestic violence, which are financed by marriage license fees.

Housing

Some family care programs have received funding from the U.S. Department of Housing and Urban Development (HUD), awarded by local housing authorities, to support housing for special populations. These grants may be used for outreach, intake and assessment, emergency shelter, transitional housing, and supportive services.

Family care programs have benefited from the federal Emergency Shelter Grants Program, which funds building rehabilitation and operating expenses for emergency or transitional housing, as well as limited amounts of essential social services and homeless prevention activities. The Supportive Housing Program, under which homeless families are given special consideration, provides for housing acquisition and new construction. **Casa Loma** in Los Angeles, and **The Rainbow/The Arc** in Gary, Ind., are two examples of programs that use this funding source. The former focuses on homeless families and the latter on victims of domestic violence.

The Shelter Plus Care Program provides rental assistance for homeless individuals with disabilities and their families, including those with chronic substance abuse problems. **Positive Images** in Detroit and **A New Life** in Philadelphia, both of which serve parents with substance abuse problems, benefit from this program. Federal and state homelessness prevention programs also are used to assist families leaving family care.

Ongoing Targeted Funding

The family care programs we surveyed also received funding directly or indirectly through a variety of ongoing publicly funded programs administered by various state agencies. These include health services, early childhood development services, child welfare and social services, alcohol and drug abuse programs, housing programs, and adolescent programs. Often these programs are funded through a combination of federal, state, and local funds.

In some cases, pregnant women and mothers with children born drug-exposed are given priority for these services; in others, family care programs must piece together support from these various sources to offer the comprehensive services their clients need. In several programs, for example, Medicaid pays for treatment services, and room and board costs are covered by an alcohol and substance abuse agency or a housing agency. In some communities, the child and family service agency collaborates with the substance abuse treatment or housing agency and provides child care and parenting education in family care and other treatment programs.

Substance abuse

Some of the family care programs serving families with substance abuse problems reported receiving funding from the federal Substance Abuse Prevention and Treatment Block Grant, which provides money on a formula basis to all states for a range of prevention and treatment services. Since 1984, the block grant has included a set aside for services for women. States were required to increase their spending for pregnant women and women with dependent children by an amount equal to 5 percent of their total block grant expenditure for FYs 1993 and 1994. Beyond FY 1994, the states must continue to expend no less than the 1994 base amount but can use a combination of any funds to reach this goal. Theoretically, states also are required to give priority to pregnant women needing services, must inform all pregnant women about the availability of treatment, and must ensure that pregnant women receive services within 48 hours of seeking treatment. As a condition of funding, states also must ensure that drug treatment providers make prenatal and child care services available, either directly or indirectly. Twenty percent of the block grant funds also must be allocated by state alcohol and drug agencies for prevention services.

Resources available through the block grant have increased only very slightly over the last few years. Nationally, about 38 percent of all substance abuse treatment services provided by state alcohol and drug agencies are supported by the block grant, with the percentage in states ranging from 11 percent to 84 percent, according CSAT.

Health and nutritional care

The federal Maternal and Child Health Block Grant funds services that help family care programs such as **Teen Parenting Services** in Portland, Maine, make sure the health care needs of their client families are met. In addition, the federal Children with Special Health Care Needs program serves children with complex medical and developmental problems. A number of family care programs also have developed links to the U.S. Department of Education's Early Intervention Program for Infants and Toddlers with Disabilities. This program provides early screening and assessment to identify needed follow-up services and treatment for children. In some programs, pregnant women and mothers with infants and young children also participate in the Special Supplemental Food Program for Women, Infants and Children (WIC), which provides nutritional supplements and counseling. The Child and Adult Care Food Program also helps with meals in some group care settings.

Child care

The federal Child Care and Development Block Grant (CCDBG) and the Social Services Block Grant both help to fund the child care components of family care programs.

However, Congress has cut the Social Services Block Grant repeatedly since its creation in 1981. Its FY 1998 funding level is now below its 1981 level, and both the Clinton Administration and Congress have proposed additional cuts. The CCDBG also is squeezed by the enormous demands on states to find child care for families on welfare as more of these parents are required to work.

Some of the family care programs we surveyed also receive help in their children's programs from volunteers participating in the federal Foster Grandparent Program. Under that program, senior citizens receive a small stipend in return for spending time with children with disabilities or other special needs in child care, educational, recreational, and institutional settings. Many family care programs we surveyed, such as **Women's Way**, a substance abuse program in Honolulu, depend on a regular corps of foster grandparents to assist in their child care programs.

Child abuse and neglect

Family care programs also look for assistance from programs aimed at the prevention of child abuse and neglect and the treatment of children already victimized by maltreatment. These efforts include the Promoting Safe and Stable Families Program (formerly the Family Preservation and Support Services Program), and both federal and state child welfare services, foster care, and adoption assistance programs.

In some of the teen parent programs we surveyed, such as **Ujima House, Inc.**, in Phoenix, federally supported foster care payments reimburse the care received by the teen mothers and their children, but only when the mother is a minor in foster care. Generally, unless a state participates in a federal demonstration program that waives applicable foster care eligibility rules, the Title IV-E Foster Care Program prevents a state from using federal funds to pay for room and board for children not removed from their parents' care. To date, efforts to alter federal law to reimburse family care programs for children's room and board have been unsuccessful, even when safety, services, and treatment are emphasized.

In some programs, state foster care dollars are used to pay for children's room and board. When funds are not available for housing children, some programs absorb the costs themselves. In these programs, whole families must live together in single rooms, so as not to reduce the total number of families the program can accommodate.

Housing

Generally, family care administrators say it is very difficult to find help to cover housing costs. Some funds are available under the Community Development Block Grant and the special grant programs described on pages 58–59. In other cases, individual residents also use their Section 8 vouchers and certificates to help pay their housing costs. Although not mentioned directly, some of the families in transition from family care might have benefited from the Family Unification Program (FUP). FUP provides Section 8 certificates to families who are at risk of having their children placed in out-of-home care, or whose children are delayed from returning home, primarily because of inadequate housing. A local housing authority in California is collaborating with a social service agency to provide residences for shared family care programs, where foster parents care for both children and their birth parents, and for transitional housing for the families as well.

Individual Benefits

Many participants in family care programs are eligible for income assistance—now through the Temporary Assistance for Needy Families (TANF) program and previously through Aid to Families with Dependent Children (AFDC). In addition, many are eligible to receive food stamps, Medicaid, and, in some instances, SSI (Supplemental Security Income) benefits. These benefits enable family care participants to help pay for room and board, cover the meals they prepare for themselves, and contribute toward the cost of other services. However, these benefits will be less available in the future. A few of the programs we studied operate on a fee-for-service basis, with private health insurance sometimes providing reimbursement.

Medicaid, the principal public health insurance program for low-income adults and children, benefited most of the family care families. Several of the programs for teen parents reported that all of their participants received Medicaid. Under Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, children and adolescents up to age 18 are eligible for a range of specialized developmental services if these services are deemed medically necessary.

Substance abuse treatment is an optional service under Medicaid. States may get Medicaid reimbursement for a range of detox and treatment services, both inpatient and outpatient, and specialized case management services, but many do not fund the full range of treatment services. A 1997 survey of state alcohol and drug directors by the Legal Action Center revealed that only 10 of 33 states responding covered hospital, non-hospital, non-hospital residential, outpatient, and methadone maintenance for persons with substance abuse problems in their Medicaid programs.

For women in small residential treatment centers, Medicaid also can be a valuable resource. However, participants in residential treatment programs with more than 16 beds are not eligible for Medicaid because of the Institution for Mental Diseases (IMD) exclusion. The IMD exclusion prohibits states from using Medicaid to pay for the care of persons between ages 21 and 65 who are housed in institutions for mental diseases of more than 16 beds, and substance abuse is considered a mental disease. This restriction on Medicaid payments was designed to discourage the warehousing of patients in large congregate care facilities. Changes over the last decade exempted some smaller treatment facilities from the exclusion. They also clarified that children's beds not used for treatment do not count against the 16-bed limit. Regardless of the size of the facility, children who are residing with their mothers, but not receiving any drug treatment, may be eligible for Medicaid. Despite these clarifications and modifications, family care administrators say the 16-bed limit is still a barrier to appropriate treatment and services for families. The exclusion is especially problematic because it not only prohibits Medicaid payments for substance abuse and mental health services but also for primary health care services, whether they are delivered in the treatment setting or off-site.

At the time of our survey, some adult family care residents also received benefits from Social Security Disability Insurance (SSDI) and SSI programs, and some children were eligible for the Supplemental Security Income Program for Children with Disabilities. However, eligibility for these benefits has been significantly restricted.

New Threats to Existing Funding

Noting the existing challenges to adequate funding for their programs, many of the family care staff we interviewed also express concern about the future. In a follow-up to our original survey, they were especially concerned about the potential negative impact of managed care and the changes in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the 1996 welfare law) on their programs' abilities to meet the needs of the women and children they serve.

Managed Care

Many family care administrators say they fear that managed care may pose significant barriers to appropriate treatment for the women and children they serve. These administrators say managed care requires so many levels of approval that referrals to family care programs will be slowed, with the result that some potential clients will become discouraged and not participate. Managed care's extreme cost consciousness may result in pressure to abandon individualized treatment approaches in favor of standardized approaches. It also will impose strict limits on the length of treatment, even though research on drug treatment for women shows that longer stays in treatment bring better results. The multiple problems that family care clients bring to treatment are also inconsistent with the emphasis managed care puts on the presenting problem. Yet it is the attention that family care gives to these multiple needs that makes it so unique.

Program administrators say they also worry that managed care organizations may not understand that child care, job training programs, and other collateral services are essential to good treatment outcomes. Some allege that the strict adherence to "medical necessity" criteria make it nearly impossible for the full range of needed social services to be reimbursed. In addition, administrators say they fear that managed care may establish geographic service boundaries that could restrict families' access to specialty programs. "We don't fit with the managed care approach," says the director of **First**

Step Home, a substance abuse treatment program in Cincinnati. Under managed care, she says, "The fewer services you provide, the more money you make. People only want to fund outpatient treatment."

1996 Welfare Law

Several provisions of the 1996 welfare law also are likely to negatively impact family care programs and the ability of the families they serve to progress toward self-sufficiency. Although our survey in many cases predated full implementation of the 1996 welfare law, family care staff already were concerned about the new hurdles it would create for their clients, many of whom have addiction, domestic violence, and other problems to deal with before sustained employment becomes a realistic option.

Victims of domestic violence

Family care staff say they fear that TANF's five-year lifetime limit on public assistance (which some states have chosen to shorten even further), together with TANF's work requirements for those receiving assistance, may make it harder for victims of domestic violence to flee their batterers. In the past, women who had been battered were able to turn to AFDC for support while they built independent lives. Now, say family care staff, victims of domestic violence, who typically lack confidence in their ability to survive independently, may feel that the TANF time limits and work requirements mean they will not have the safety net they need to escape their abusers.

The 1996 welfare law allows states to give special attention to the needs of recipients of TANF who have experienced domestic violence. Under TANF's Family Violence Option, states can certify that they have established standards and procedures to identify TANF recipients who are victims of abuse and refer them to counseling and supportive services. They also have the option to waive various program requirements, including time limits, which would make it difficult for women to escape domestic violence or would unfairly penalize them. Within a year after enactment of the 1996 welfare law, 19 states had exempted victims of domestic violence from their time limits in some way, according to the Urban Institute.

TANF's requirement that a mother sign over her rights to collect child support to the state and cooperate with its efforts to establish paternity and collect child support in order for the child to receive public assistance may also have a chilling effect on battered women's willingness to apply for assistance. Although this was previously a requirement to receive aid under AFDC, in the past, federal law required state welfare agencies to make good cause exceptions to it, and federal regulations specified that good cause could be claimed when cooperating with efforts to identify the father would pose a threat to either the parent or child. Now states decide for themselves what counts as a good cause exception and whether the welfare or child support agency will make the determination.

Parents with substance abuse problems

Family care staff also say they worry that the time limit and work requirements in the 1996 welfare law may interfere with their clients' ability to enter or continue substance abuse treatment. For women receiving public assistance under TANF, the time a woman spends waiting for treatment and participating in treatment generally is counted against her two-year time limit for finding a job and her five-year (or less, depending on the state) lifetime limit on benefits. Utah and Oregon are examples of states that allow parents to count activities like substance abuse treatment and mental health counseling toward fulfilling their work requirements, and more states should do so.

In addition, several provisions in the 1996 welfare law threaten to deny TANF and other benefits to some family care participants and graduates with previous legal troubles. The law imposes a lifetime ban on receipt of cash assistance and food stamps by any individual who is convicted of a felony related to the possession, use, or distribution of a controlled substance that occurred after August 22, 1996. In our survey, administrators of some family care programs for women with substance abuse problems estimated that 50 percent to 60 percent of their participants have prior drug convictions. A 1997 survey by the Legal Action Center of drug and alcohol treatment programs serving women with children reported that an average of 24 percent of clients who received AFDC had felony drug convictions.

The benefits ban could discourage women who are working toward regaining custody of their children but feel they cannot succeed without some assistance to help them make the transition to self-sufficiency. Fortunately, states may opt out of this provision or limit the period or nature of the ban. As of the end of 1997, about one-third of the states had narrowed the scope of the ban or opted out entirely. A related provision that may affect family care programs and their participants prohibits states from providing TANF, SSI, public housing benefits, and food stamps to anyone in violation of their probation or parole conditions.

The elimination in 1996 of drug addiction and alcoholism as a basis for disability benefits under the adult SSI program may also deny needed support to some women in family care programs who were receiving SSI at the time of our survey. Before March 29, 1996, individuals receiving treatment for drug abuse or alcoholism could qualify for SSI benefits if they were financially eligible. Since then, however, no individual may qualify for SSI solely on the basis of drug addiction or alcoholism but must have another disability. Those adults who lose their SSI will also lose their Medicaid and any access to Medicaid-funded treatment services. Immigrant parents are at special risk because the 1996 welfare law prohibits most legal immigrants who are not citizens from receiving SSI and SSI-linked Medicaid. The 1996 welfare law also made it more difficult for low-income children with disabilities to qualify for SSI, a change that is disproportionately harming children with mental and emotional disabilities and affecting some children in family care.

Teen parents

With some exceptions, the 1996 welfare law requires minor parents who wish to receive cash assistance to live with a parent, legal guardian, or other adult relative. If the state determines that a minor parent and her child cannot live safely at home, the state welfare agency is obligated to provide, or to assist the family in locating, an appropriate adult-supervised living arrangement, or to decide that the minor's current living arrangement is appropriate.

The impact of this provision on teenage parents in family programs is difficult to predict. On the one hand, it may give states the impetus to establish more family care programs for minor parents and their children, since TANF funds could be used for this purpose. On the other hand, young mothers progressing well in family care may be forced to return to less supportive living arrangements with their parents. Professionals who work with teens believe that some minor parents who cannot return home will forfeit their assistance without first determining whether the state would require them to live with their parents.

Donations of Time, Expertise, Gifts, and Supplies

Family care programs rely to varying degrees on volunteers and donations to enrich their programming. On one end of the spectrum is a Phoenix teen pregnancy program, **Ujima House, Inc.**, which is funded by a local Baptist church. With the exception of one paid staff member, who serves as house mother for the parenting teens, the program relies completely on volunteers. Volunteer professionals in the community are organized into specialized teams that provide counseling, education and skills-training, health care, mentoring, and spiritual guidance. Other volunteers are responsible for program administration, marketing, public relations, and fundraising.

At the other end of the continuum are a handful of programs we studied that choose not to use volunteers at all. These programs explain their decision by citing the time and expense it takes to screen, train, and supervise volunteers; difficulties in recruiting people interested in working with such high-need families; trouble in retaining committed volunteers; and confidentiality and liability concerns.

Most of the family care programs we studied, however, use at least some volunteers to avoid gaps in the services they provide. At the **Greentree Shelter** for homeless families in Bethesda, Md., two special education teachers volunteer at the after-school program. The assistant director says it has made a world of difference: "We never could have afforded specialists."

Generally, volunteers assist with child care and children's groups, organize field trips, help in the office, do yard work, keep the facility in good repair, and manage donations. **Middle Way House**, a domestic violence program in Bloomington, Ind., estimates that it receives more than $150,000 worth of volunteer labor each year.

Some programs have a volunteer coordinator to recruit, screen, train, and supervise volunteers. Chicago's **Rainbow House** requires its volunteers to participate in 40 hours of training before working with the victims of domestic violence it serves. The director of **HerStory House**, a program for families facing domestic violence in Rutland, Vt., says her agency learned to screen more carefully when staff realized that some volunteers appeared to be coming in to receive services and were not emotionally strong enough themselves to help other victims. "If we don't watch out," she says, "we're going to be taking care of our volunteers." The program staff also decided not to accept teen volunteers in order to avoid confidentiality breaches in cases in which a young volunteer knows a client's child.

In addition to volunteer services, most family care programs receive a variety of in-kind donations, and many programs actively solicit what they need. The director of **HerStory House** says the program is so active in soliciting donations of everything from appliances to toilet paper that it seldom has to buy supplies. The program has created a list of needed items that it distributes to people and organizations that want to help. (See box on page 67.) Family care programs receive significant help from individuals, businesses, and other community groups, generally in the form of time, expertise, supplies, or gift items. Some of these are listed below. Other resources for in-kind contributions are listed in the box on pages 58–59.

Individuals

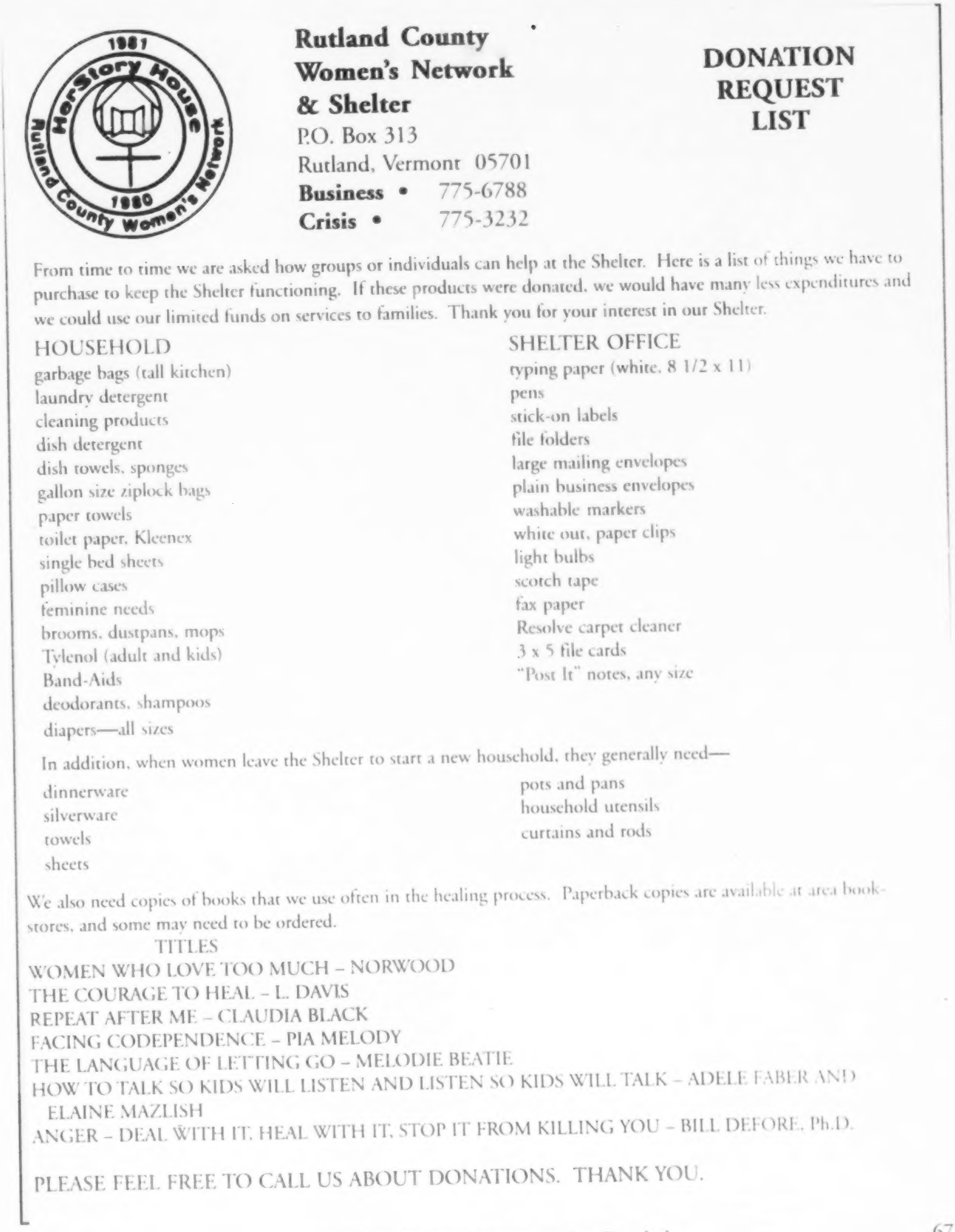
A variety of individuals volunteer at the family care programs we surveyed, from senior citizens (often under the aegis of the federal Foster Grandparent Program), to professionals, to students fulfilling internships.

- A man who read about **Flowering Tree** in a local newspaper faithfully sends the Pine Ridge, S.D., substance abuse program $30 a week for the residents' activity fund.
- At one program, the principal of a local school volunteers to read stories and help with child care.
- At **First Step Home** in Cincinnati, serving families struggling with substance abuse, a group of local women come in regularly to conduct a writing group.
- At **Women's Way** in Honolulu, also a substance abuse program, a retired school teacher offers tutoring to women preparing to take the general equivalency diploma (GED) exam.

Businesses

Many kinds of businesses donate a variety of goods and services to family care programs.

- The Melloncrot Chemical Company in St. Louis established a committee to coordinate the company's volunteer activities at the **Grace Hill** program for families with substance abuse problems. Everyone from the plant manager on down volunteers regularly to put on an annual barbecue, graduation celebration, and open house. The committee also makes sure the children receive holiday gifts each year and tickets for recreational events.
- At **Women's Way**, hairstylists come in regularly to give free haircuts.
- Many programs receive donations of used clothing, but in Portland, Maine, **Teen Parenting Services** receives thousands of dollars worth of new clothes several times a year from Bass Shoes. "It's a great self-esteem booster for our clients, who feel uncared for and who couldn't otherwise afford a new wardrobe," says the director. A local pizzeria also donates seven hot pizzas every Friday night.



Rutland County
Women's Network
& Shelter
P.O. Box 313
Rutland, Vermont 05701
Business • 775-6788
Crisis • 775-3232

DONATION REQUEST LIST

From time to time we are asked how groups or individuals can help at the Shelter. Here is a list of things we have to purchase to keep the Shelter functioning. If these products were donated, we would have many less expenditures and we could use our limited funds on services to families. Thank you for your interest in our Shelter.

HOUSEHOLD

garbage bags (tall kitchen)
laundry detergent
cleaning products
dish detergent
dish towels, sponges
gallon size ziplock bags
paper towels
toilet paper, Kleenex
single bed sheets
pillow cases
feminine needs
brooms, dustpans, mops
Tylenol (adult and kids)
Band-Aids
deodorants, shampoos
diapers—all sizes

SHELTER OFFICE

typing paper (white, 8 1/2 x 11)
pens
stick-on labels
file folders
large mailing envelopes
plain business envelopes
washable markers
white out, paper clips
light bulbs
scotch tape
fax paper
Resolve carpet cleaner
3 x 5 file cards
"Post It" notes, any size

In addition, when women leave the Shelter to start a new household, they generally need—

dinnerware
silverware
towels
sheets

pots and pans
household utensils
curtains and rods

We also need copies of books that we use often in the healing process. Paperback copies are available at area bookstores, and some may need to be ordered.

TITLES
WOMEN WHO LOVE TOO MUCH – NORWOOD
THE COURAGE TO HEAL – L. DAVIS
REPEAT AFTER ME – CLAUDIA BLACK
FACING CODEPENDENCE – PIA MELODY
THE LANGUAGE OF LETTING GO – MELODIE BEATIE
HOW TO TALK SO KIDS WILL LISTEN AND LISTEN SO KIDS WILL TALK – ADELE FABER AND ELAINE MAZLISH
ANGER – DEAL WITH IT, HEAL WITH IT, STOP IT FROM KILLING YOU – BILL DEFORE, Ph.D.

PLEASE FEEL FREE TO CALL US ABOUT DONATIONS. THANK YOU.

BEST COPY AVAILABLE

- A janitorial supply company donates cleaning supplies to **Family Sushine Center**, a domestic violence program, in Montgomery, Ala.

- A local car dealer has donated the use of a van to **Domestic Violence Intervention Services, Inc.**, in Tulsa, Okla.

Religious Organizations

Some religious organizations are very involved in the work of their local family care programs. As we noted above, **Ujima House, Inc.**, is funded almost entirely by a church. Other religious organizations play more limited but valued roles.

- A neighborhood church in Philadelphia, which many staff of **A New Life** attend, has adopted the substance abuse program and provides a steady stream of donated household and other items.

- At **Hutchinson House**, another substance abuse program in Philadelphia, the aftercare program is largely staffed by volunteers from several local churches who serve as bridges to the community. Each volunteer mentor is matched with a new program graduate, with whom she meets at least weekly. Every month, all of the mentors and graduates meet in a large group to acknowledge the progress they are making together.

- At the **RBHA—Recovering Families Project** in Richmond, Va., a local church supplies materials for and conducts the GED program.

- A church in Libertyville, Ill., provides transportation for worship services for residents of **Women's Residential Services** struggling with substance abuse.

Community Groups

Among other services, community groups looking for service projects contribute gifts and offer entertainment and recreation opportunities to mothers and children in family care.

- A Girl Scout troop in Pennsylvania that has adopted the **Flowering Tree** program sends the families holiday gifts each year.

- One night each month, called Family Unity Night, the Denver Junior League provides an evening of programming for previously homeless families at **Warren Village**.

- The Women in Construction organization comes monthly to **Women's Way** to work with staff and clients in refurbishing the facility.

- A swimming pool in Wheeling, W. Va., donates pool time to families from **Crittenton Programs, Inc**.

- A women's auxiliary in Yakima, Wash., donates car seats and homemade quilts for the babies at **Riel House**, a program for parents with substance abuse problems.

Making a Case for Investing in Family Care

It is true that the challenges in funding family care programs are significant and that new struggles are ahead, but advocates must not be deterred. The human and fiscal costs of not investing in children and families like those served by the family care programs we surveyed are enormous.

We heard repeatedly from the family care staff we interviewed about the harm that befalls families who do not have the opportunities for healing offered by family care programs, all of which have a significant cost attached. Many of the parents served, especially in substance abuse programs, already had had some contact with the criminal justice system and some had been incarcerated. Many had children in foster care or had had some contact with staff of child protective services agencies. Others had children being cared for by relatives with the help of public assistance. Some came to the programs with children whose developmental needs required expensive and extensive services over a long period, some of which might have been avoided if caught earlier. Others had concerns about their older children whom they saw turning to alcohol, other drugs, and violent relationships. The programs saw firsthand the toll that domestic violence, substance abuse, and homelessness can take on one's health and the enormous implications that has for public health costs. There are lost opportunities as well for education and employment that will jeopardize not only their own futures but also those of their children.

As we explore how to continue or expand family care programs or seek new ways to provide more comprehensive services to children and their parents with similar problems who come to the attention of the child welfare system, we must form alliances with others who will benefit from the investments made in these families. One of the particular challenges in making a case for investments in prevention and treatment for families served by family care is that the cost savings that are realized often do not benefit directly those who made the investments. Child welfare and substance abuse prevention and treatment agencies, for example, get little reward when incarceration rates decline, health costs drop, or employment increases. Yet many of us stand to benefit from the successes of family care programs, especially the children—our next generation.

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Chapter 6

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WHAT WE KNOW ABOUT THE SUCCESS OF FAMILY CARE

A frequently asked question about family care programs is: Do they work? It is not yet possible to answer that question on the basis of extensive research data because formal systematic evaluations of family care programs are just getting underway. Yet there is little doubt in the minds of those most closely involved with family care—program staff and families—that it does make a difference in many participants' lives. Program staff attribute the success of family care to a number of characteristics that are typically weak or altogether lacking in traditional social services and treatment programs. We discuss those characteristics in Chapter 3. Many of these elements were added to earlier program designs specifically to make the programs more responsive to the needs of the women and children who participate.

It is useful to review the characteristics that many believe make family care effective before we look at the research data on family care. They include:

- Comprehensive services that address the complex needs of parents, children, and the family unit.
- Priority attention to children's safety, parenting education and support, and strengthening the parent–child relationship.
- Longer treatment timelines and aftercare that allow genuine change and healing to take place.
- Aftercare, often including transitional housing, to ease the family's return to the community and to support parents' efforts to establish independent and productive lives.
- An accepting yet demanding treatment environment characterized by clear expectations and standards, as well as an understanding that relapses and setbacks are part of recovery.
- Committed, skillful, and flexible staff members who are able to address diverse and emerging needs.
- Active peer support among residents while in the program and as they make the transition back into the community.

Challenges in Evaluating Family Care Programs

Family care staff typically work with clients to map out goals for their participation in family care and track their progress through treatment and sometimes beyond. These efforts yield a great deal of powerful anecdotal evidence about the effectiveness of family care, but the information is obviously different from data derived from systematic research on outcomes for children and parents. Our interviews with family care administrators and our own review of materials from the programs we surveyed and other similar programs suggest that descriptive information is generally available on the children and parents served and the treatment and services provided. However, only scattered formal evaluations of parent and child outcomes from family care programs have been undertaken to date.

Limited Resources and Expertise

Formal evaluations are costly and time consuming, and the family care administrators we interviewed generally say scarce resources are the main reason why there has been no extensive research. Although several programs that we surveyed have full-time researchers on-site, most programs lack this kind of expertise. It costs a substantial amount of money to hire an outside evaluator. Some have teamed up with researchers at universities or independent firms. Then, too, the evaluation process requires extra time and effort from regular program staff, who are typically already giving their all. Given the limited human and financial resources available for family care, program administrators know that choosing to spend scarce resources on evaluation means they will have less money to spend on treatment services. Since providing services for their participants is family care's first priority, evaluation generally has taken a back seat. Many service providers also question whether rigorous evaluation would actually benefit those served by family care, citing the lack of feedback program staff typically receive from evaluators. Some family care administrators believe that evaluation requires a rigidity and discipline that is inconsistent with the supportive environment family care staff painstakingly create.

Complexities Inherent in Comprehensive Service Models

In addition to the financial and intangible costs of evaluation, other barriers to evaluation that are significant and complex need to be addressed. The comprehensive nature of family care makes it particularly challenging to evaluate. Family care uses multiple strategies and treatment approaches involving multiple service systems (substance abuse, domestic violence, mental health, health, and early childhood development). Family care seeks to achieve these multiple goals for the parent and child individually and for the parent and child in relationship to each other. It is extremely difficult to isolate the various elements of family care to determine the influence of each on specific child and parent outcomes; such process evaluations are especially difficult in very small programs, like some in our survey. Generally though, any thorough evaluation of family care programs must assess the changes in parents' knowledge of child development, in parenting styles, and in parent–child interactions that occur over the course of treatment. This presents another challenge for researchers designing evaluations of family care.

Inapplicability of Traditional Evaluation Designs

In *Common Purpose: Strengthening Families and Neighborhoods to Rebuild America*, social analyst Lisbeth Schorr discusses the reasons that the traditional evaluation model—with its interest only in narrow quantifiable variables and its reliance on randomly selected experimental and control groups—is inadequate for evaluating broad, complex, and interactive interventions aimed at multiple outcomes. Although Schorr does not specifically refer to family care programs, they resemble the kinds of interventions that she says have been poorly served by the traditional research methodologies. Schorr describes "a new evaluation mind-set [that] is emerging that promises to expand vastly our understanding of what works." This new mind-set has at least four attributes, which seem particularly responsive to the criticisms of evaluation that we heard from the family care staff members we interviewed. The new approaches to evaluation are built on "a strong theoretical and conceptual base, emphasize shared interests rather than adversarial relationships between evaluators and program people, employ multiple methods and perspectives, and offer both rigor and relevance." More imaginative and creative research methods that embody these attributes can provide a truer picture of the impact of complex comprehensive social services like family care.

In this context, it is important to note that most evaluations of traditional drug treatment programs, while demonstrating their effectiveness generally have not specifically examined their impact on women (see box on pages 74–75). Even the few that have done so have not attempted to measure changes in women's ability to protect and nurture their children or in the quality of the mother–child relationship as a result of treatment. Finding the right assessment tools for these tasks can be difficult. For example, after site visits to 35 residential programs for women and children funded by the federal Center for Substance Abuse Treatment (CSAT), researchers reported that standardized assessment instruments for this population of women and children are scarce. Some grantees had adapted existing measures; some had developed totally new ones; others did not know where to start.

Special Challenges in New and Evolving Programs

Another reason family care programs are challenging to evaluate is that many are evolving as they operate. In many programs, staff have tried to do a better job of meeting their clients needs by modifying the services—extending the length of stay, for example, or adding new service components—as program weaknesses have been identified. Although such mid-course corrections are good for clients, they can play havoc with a formal experimental design. It also is difficult to evaluate new programs because there is always a shake-down period as they get started. Many family care programs are just being developed or are in the process of implementing more intensive children's services.

Evaluating family care is further complicated because some programs lose a large number of families early in treatment. This is especially true for programs just getting underway. Many programs we studied are working hard to improve completion rates. Data on program effectiveness may be skewed by large numbers of early leavers, unless evaluators specifically take this problem into account. The challenge is to evaluate the success of the program for those who complete it and also to assess why other clients depart early and how they fare.

For evaluation purposes, outcomes for a program's dropouts can be usefully compared with outcomes for clients who graduate. At least one program we surveyed, **G.A.P.P. Family Enrichment Center** in Atlanta, is comparing outcomes for its graduates with outcomes for program dropouts, clients on a waiting list, and a matched cohort of women admitted to other alcohol and drug treatment programs in Atlanta. The extra resources needed to track those who leave early is another barrier to such studies of family care participants.

As real as these research challenges are, we do not offer them to excuse the dearth of rigorous assessments of family care. In acknowledging these difficulties, we wish to emphasize the importance of the research studies now underway and the importance of devoting more resources to well-conceived evaluations designed to identify the specific components and characteristics of family care that have the most lasting positive impact on participating families.

Evaluation Activities

Few of the 50 family care programs we studied had formal evaluations available, although family care programs for women with substance abuse problems and their children are more likely than others to have evaluations underway. CSAT requires formal evaluations of the residential substance abuse treatment programs for women and children that it funds, and some of these programs appear to have developed thorough research plans. Several efforts to assess evaluation data from these CSAT-funded programs, one of them a cross-site evaluation, are underway.

An analysis of the first 11 Residential Treatment Programs for Women and Children, for which federal funding officially ended in October 1997, is expected before the end of 1998. This report, which is being prepared for CSAT by Policy Research Incorporated, will include data on outcomes for women and children, as well as a discussion of the lessons learned about the treatment of children, treatment of women, the programs' interactions with the community, and important issues in evaluation. Those involved in the review say that all of the programs showed a significant reduction in the women's alcohol and drug abuse. Some programs also showed improvements in women's employment status, reduced client involvement with the criminal justice system, and positive outcomes for children. Over the next year, most of the 11 programs plan to publish additional reports on their outcomes for women and children in academic and social service journals.

CSAT also has underway a national cross-site

Is Substance Abuse Treatment Effective?

Numerous studies over the last decade have demonstrated the many positive effects of substance abuse treatment. Much more needs to be done, however, to assess the effects on women, and mothers in particular. The Legal Action Center reviewed and summarized the available research on treatment effectiveness in its 1997 report, *Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients*. The report found:

Treatment increases employment and earnings.

- Participants in the National Treatment Improvement Evaluation Study (NTIES), which evaluated outcomes for 5,700 clients in 78 federally funded treatment programs, increased their employment by 18.7 percent one year after treatment.
- Participants in a California study (CALDATA) who completed more than four months of residential treatment increased their employment by more than 30 percent, despite a recession in the state during the study period.
- In Oregon, individuals increased their weekly earnings from $154 to $278 in the three years after completing treatment.
- In Minnesota, full-time employment of clients in the public treatment system increased by 18.1 percent in the six months after treatment compared with the previous six months.
- Of study participants in Texas who were unemployed when they entered treatment, 59 percent were employed one year after finishing treatment.

Treatment reduces welfare rolls.

- The number of NTIES participants receiving welfare decreased by 10.7 percent one year after treatment.
- Women participants in CALDATA who received welfare before they entered treatment reduced their welfare participation by 22 percent after treatment.
- In Oregon, individuals who completed treatment reduced their food stamp use dramatically.

Treatment saves health care costs.

- Among CALDATA participants, drug and alcohol treatment reduced hospitalizations by 36 percent for physical health problems, 58 percent for drug overdose, and 44 percent for mental health problems.

evaluation of 50 of the family care programs funded under the Demonstration Grant Program for Residential Treatment for Women and Their Children (26 projects) and the Services Grant Program for Residential Treatment for Pregnant and Postpartum Women (24 projects). This evaluation, being conducted by Caliber Associates, with outcome analyses expected to begin in late spring 1999, will look across programs at a client characteristics and features of residential treatment that may affect retention and outcomes for clients.

- Minnesota's public treatment initiative saved $7.9 million in medical hospital days, $10.8 million in psychiatric hospital days, and $3.3 million in detox admissions.
- One perinatal treatment program in Baltimore saved $18,000 to $26,500 per treated mother–infant pair compared with the cost of treating one drug-exposed infant.

Treatment reduces drug and alcohol use.

- Among participants in NTIES, crack cocaine use decreased by 50.7 percent and heroin use by 46.5 percent.
- Among CALDATA participants, crack, cocaine, and amphetamine use declined by almost one-half; heroin use by over one-fifth; and alcohol use by almost one-third.
- In the Treatment Outcome Prospective Study (TOPS), regular marijuana use among residential clients in the first three months of treatment fell from 64 percent to 5.1 percent.
- A 1994 study of 65,000 client treatment outcomes (CATOR) showed that about 60 percent maintained total and continuing abstinence in the first year after treatment. Weekly participation in self-help groups, such as Alcoholics Anonymous, boosted that percentage to 73 percent and participation in once- or twice-weekly professional aftercare increased it to 85 percent.

Investment in treatment and prevention reaps hefty returns for taxpayers and state budgets.

- The 1994 CALDATA study found that each dollar invested in alcohol and drug treatment saved taxpayers $7.
- A 1996 Oregon study determined that each dollar of state money invested in alcohol and drug treatment services saved taxpayers $5.60.
- A 1997 analysis of CALDATA data for welfare recipients calculated that each $1 invested in alcohol and drug treatment saved taxpayers $2.55.

For the sources of these data as cited by the Legal Action Center, see Appendix E, Endnotes, pages E-5 and E-6.

The national cross-site evaluation seeks to answer four questions:

- What is the more appropriate length of stay (six months versus 12 months) in terms of client outcomes for different individuals and family units?
- What client factors predict retention in residential treatment, successful completion of treatment, and treatment outcomes?
- Does family involvement in therapeutic services predict a woman's retention in residential treatment, successful completions, and treatment outcomes?
- Does the overall health and welfare of children who participate in residential treatment with their mothers improve?

Data will be collected on parents and children. Parent outcomes of interest include successful program completion, alcohol and other drug use, socioeconomic well-being, employment status, involvement with the criminal justice system and child protective services, mental and physical health status, and family functioning (including incidence of child abuse and neglect). Child outcomes of interest include birth outcomes, health status, problem behavior indicators, involvement with the juvenile justice system, and living conditions (including reunification).

Cross-site analyses will identify similarities and differences in project staffing, project implementation, services, clients, and client outcomes. Such analyses will provide program-wide findings on the efficacy of residential treatment for pregnant and parenting women and may be useful in identifying specific strategies and best practices that are effective with specific populations and/or in specific settings.

The cross-site evaluation is a major undertaking in that it necessitates the collection of comparable data at comparable time points to generate a common data set across grantees, which vary as to their stage of development, target population, treatment philosophy, modality, and service delivery approach. Such a database permits comparisons between different groups of grantees and allows CSAT to assess how well its programmatic goals and objectives are being met. The cross-site evaluation builds upon local evaluation efforts and provides a uniform national perspective regarding program accomplishments and a uniform data set to be used to address public health issues, congressional and Administration mandates, and data collection needs.

Funders of family care programs other than the federal government also have requested and/or conducted program evaluations. They have included the United Way, state domestic violence coalitions, and state agencies such as housing authorities, human services departments, children and family service agencies, and alcohol and drug treatment agencies. Many family care administrators say their programs have been reviewed by licensing agencies in their state or jurisdiction.

When the programs we surveyed had the benefit of formal evaluation data, they typically used the information to help improve their services. For example, when evaluations undertaken by **Flint Odyssey House, Inc.**, in Flint, Mich., serving families with substance abuse problems, revealed that children moving from foster care into treatment with their mothers were not adjusting well, the program restructured the process and time frame for reunification. **Flint Odyssey House, Inc.**, also is using specific assessments of children's development to identify early developmental delays, then using the evaluation data to improve services for children in its new Integrated Children's Program.

Research conducted by **Project BASTA** in Boston, which serves young pregnant and postpartum victims of domestic violence, showed that although the program was meeting its goals for improving its participants' basic life management skills and reducing their levels of stress, it was not meeting its goal for changing attitudes about parenting. Therefore, the program improved its parenting resources, concentrating more on staff modeling of good parenting practices, new goals for parent–child involvement, and a new curriculum to improve mothers' understanding of child development.

Even if programs have not yet undertaken formal evaluations, they are likely to gather feedback from clients to help guide program refinements. Most all of the programs we studied track demographic information on the families they serve, the services received, and sometimes the whereabouts of families who relocate. The **Family Sunshine Center** in Montgomery, Ala., a domestic violence program, asks each woman at discharge to evaluate the services she received. **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., asks residents to evaluate the program generally, as well as the particular classes they attended. **Greentree Shelter** in Bethesda, Md., asks its formerly homeless residents at discharge to review numerous aspects of their shelter experience: its safety, cleanliness, and adequacy; services for their children and help with parenting; and links to community services.

In addition to exit surveys, a number of the programs studied—such as the **Integrated Family Treatment Program**, serving families facing substance abuse in San Antonio, and **Domestic Violence Intervention Services, Inc.**, in Tulsa, Okla.—ask participants to fill out satisfaction surveys every three or six months. At **Seton Home** in San Antonio, staff members fill out evaluations of the teen mothers leaving the program in order to record their views of the progress each one made.

Warren Village in Denver is developing a database of former residents. The program for formerly homeless families will collect data on marital status, income, housing, employment, and education at the time of exit from the program, as well as current information in each category.

While outcome data for family care programs are scarce, even fewer cost–benefit data are available, although CSAT's 1995 publication, *Producing Results . . . A Report to the Nation*, projected that treating addicted pregnant women may save more than $100,000 per client in costs associated with a drug-involved birth, welfare, foster care, and intensive medical care and treatment. **Exodus** in Compton, Calif., is one program in our survey that noted it is attempting to compare the cost of its multifaceted treatment for families with the projected costs of neonatal intensive care, child protective services, foster care, developmental services, and special education for drug-affected families who do not receive services.

What Existing Data Reveal

As part of our survey, we asked family care administrators to send us the results of any formal or informal research on their programs. For the most part, the data we received, as well as other published data on family care, come from programs serving women recovering from alcohol and other drug problems or domestic violence. This research generally focuses on changes in the parents' health and functioning and in their knowledge and attitudes about parenting as a result of family care. Some of the research also assesses family care's impact on children's development. Below we present some of the data we found most revealing.

Impact on Women

Few of the women who enter family care, particularly those with histories of substance abuse, had the kind of early nurturing that fosters high self-esteem. Many experts in drug treatment, including researchers at the Coalition on Addiction, Pregnancy and Parenting (CAPP) in Cambridge, Mass., and Health and Addictions Research, Inc., in Boston, have found that low self-esteem is a significant factor in women's substance abuse, either as an antecedent, a consequence, or both. In fact, the characteristic mentioned most frequently by researchers studying substance use and abuse in girls and women is low self-esteem.

Increasing self-esteem and decreasing depression and stress

Treatment experts maintain that it is critical for women who are seeking to conquer their addictions and achieve self-sufficient lives to develop healthier self-esteem in order to overcome the emotional, educational, financial, and social obstacles they face. The program coordinator of **Women's Residential Services** in Libertyville, Ill., says, "Self-esteem and the ability to deal with stress play a major role in the development, progress, and recovery of persons who are drug dependent." Research shows that self-esteem also is related to mothers' ability to nurture their children. A study by Myra Christensen and others, published in 1994, found that maternal self-esteem affects the quality of mother–child interactions.

Mothers found by child protection agencies to be neglectful had significantly lower overall self-concepts than a comparison group. Little wonder, then, that one of the tasks of family care programs is to help mothers strengthen their feelings of self-confidence and self-worth. Some women need to be "reparented" and nurtured so that they will have the competence and emotional readiness needed to assume the challenges of parenthood.

- **Women's Residential Services** found that 95 percent of entering clients had levels of self-esteem that the Barksdale Self-Esteem Evaluation classifies as "seriously disadvantaged." At the time of discharge, all but three of the 86 women studied had significantly higher self-esteem scores. In the same study, participants' stress levels also improved, as measured by another Barksdale index, with all but five of the 86 women showing significantly lower personal stress scores at discharge than at admission.

- Eighty-nine percent of the women with substance abuse problems entering the **Pregnant & Postpartum Women & Infants Program** in Chicago had elevated levels of psychic stress and pathology in overall psychological functioning, most notably depression. At discharge, the majority of participants showed reduced levels of depression, enhanced overall psychological functioning, and improved attitudes toward children and child-rearing. Reduced levels of depression, addiction, and other problems mean that program graduates are able to respond and relate more appropriately to their children.

- Preliminary data from the first year of an evaluation of the Integrated Children's Program at **Flint Odyssey House, Inc.**, a substance abuse program in Flint, Mich., show encouraging improvements in participants' self-esteem and parenting, as well as decreases in depression, but it is too early to know if these changes will be statistically significant.

- At **Families in Transition** in Miami, participants showed significant decreases in feelings of social isolation during the course of substance abuse treatment.

- Data gathered by **Greentree Shelter** in Bethesda, Md., from formerly homeless residents at discharge documented that they felt better about themselves and their relationships with significant others than when they arrived. Residents who visited the program after leaving also reported less social isolation. More than 90 percent stated that they kept significant friendships they had made while at the shelter, and about 80 percent had made new friends since leaving the shelter; 71 percent were involved in their children's schools, and 50 percent attended parent–teacher meetings.

- Looking back on their experiences at **Project BASTA** in Boston, the young victims of domestic violence said their relationships with staff and other residents were the most valuable aspects of the program. They reported that good parenting skills and the ability to respond appropriately to domestic violence were the most important skills they had learned. Other outcomes that had most affected their lives were increased self-confidence, a sense of independence, the ability to trust, and the ability to communicate better with their children and others.

Alleviating harmful behaviors

The research shows that family care treatment improves the likelihood that participants will stop using drugs, avoid violent relationships, and stay out of the criminal justice system, and that teen participants will avoid repeat pregnancies.

Drug and alcohol abuse

- According to CSAT, a study of nearly 330 women receiving services under its Pregnant and Postpartum Women program, for whom treatment follow-up data were available by the end of the third quarter of FY 1996, revealed a 73 percent reduction in the number of women using illicit drugs from intake to post-discharge.

- A preliminary analysis of women in 11 of CSAT's Residential Programs for Women and Children revealed a 66 percent reduction in the number of women reporting alcohol and other drug use between admission and the post-discharge follow-up. Women completing treatment showed more improvement than those not completing treatment.

- Graduates of the **G.A.P.P. Family Enrichment Center** in Atlanta showed significant improvement in income and family/social relationships, as well as reductions in alcohol and drug abuse as measured by the Addiction Severity Index.

- **Families in Transition** in Miami reported that all of the women entering the program were using drugs at intake, but none was using drugs at discharge, and just 13 percent relapsed after discharge.

- The **Exodus** program in Compton, Calif., serving women who average 10 years of drug abuse, reported that for the 1996–1997 program year almost all of the clients interviewed remained sober and drug free at least six months following discharge.

- A study of former participants of the Amity Center for Women and Children in Tucson, Ariz., a family care program not in our survey, found that 69 percent of those who completed treatment *did not* return to abusing alcohol or other drugs at follow-up. In contrast, 64 percent of those who dropped out of treatment *did* so.

- Prototypes Women's Center in Pamona, Calif., another family care program not in our survey, reported at a six-month follow-up of 124 women who had averaged 239 days in the program that 85 percent were drug free in the three months immediately before the follow-up interview.

Repeat pregnancies

- The Progressive Policy Institute study of Second-Chance Homes reports that while the national average for repeat pregnancies by teens is between 11 percent and 26 percent in one year and 50 percent within two years, at **Bridgeway** in Lakewood, Colo., only 8 percent of the teens became pregnant again in the two years following completion of the program. At **Seton Home** in San Antonio, only 10 percent of the teen mothers become pregnant again within one year.

Involvement in the criminal justice system

- Of the women in the CSAT follow-up study of the Pregnant and Postpartum Women's program, 90 percent were not involved with the criminal justice system following treatment.

- The analysis of the 11 CSAT Residential Women and Children's programs found a 79 percent reduction in criminal justice involvement from intake to follow-up, with the odds much improved for those completing treatment.

- The Prototypes Women's Center six-month follow-up of 124 women reported that 13 percent had been arrested since leaving treatment. For those in treatment for more than 180 days, the arrest rate was 4 percent, whereas for those treated for 180 days or less, the rate was 28 percent.

Violence

- Eighty-five percent of the women who stayed at **Middle Way House** in Bloomington, Ind., chose not to return to an abusive relationship at the end of their shelter stay; 73 percent increased their knowledge of domestic violence; and 61 percent found housing on their own when they left the shelter.

- In a follow-up of former **Project BASTA** participants who had been gone from the program for two months to two years, 84 percent to 92 percent of the women said they had less physical, sexual, or emotional violence in their lives than when they entered. Nearly two-thirds had experienced no violence or abuse in their relationships since leaving the program. During residence, 89 percent of participants increased their use of positive coping strategies in response to violence, and 93 percent increased their basic life management skills.

- Several domestic violence programs where parent agencies offer treatment for abusers on-site have gathered data on the success of those activities. **Domestic Violence Intervention Services, Inc.**, in Tulsa, Okla., for example, reported that 82 percent to 85 percent of the 110 male batterers receiving a high or medium level of involvement by the program in 1996 and 1997, most of whom graduated, had a record clean of post-treatment arrests and other police incidents.

Enhancing education and employment

There also are indications that family care increases the likelihood that its graduates will be in school, in training, or in jobs.

- Thirty-five percent of women in CSAT-funded Pregnant and Postpartum Women's programs for whom there were follow-up data by the end of the third quarter of FY 1996 were employed following treatment.

- For the 100 participants in the 11 original Residential Women and Children's program for whom there were follow-up data, the employment rate was 34 percent post-discharge; none of the women had been employed at intake. Women who completed treatment were significantly more likely to be employed at follow-up than women who did not complete treatment.

- A recent survey of clients with substance abuse problems participating in the aftercare program at **G.A.P.P. Family Enrichment Center** showed that 44 percent are no longer receiving public assistance. Thirty-seven percent are employed, and 7 percent are enrolled in school or job training programs.

- A review of participants in **Families in Transition**, a substance abuse program, shows that they all relied on public assistance at admission, but at graduation, just over half did not receive it or had only some reliance on it. Fifty percent of the graduates were employed or in school at follow-up, whereas none was employed or in training at admission.

- Of the **Exodus** clients interviewed six months after discharge, 66 percent of those in recovery were either enrolled in school or a training program or were working part-time. Others reported actively seeking employment or being involved in volunteer work.

- The six-month follow-up of the 124 families from Prototypes Women's Center reported that 57 percent of the women had jobs and 21 percent were in school or training. Three months after substance abuse treatment, only 37 percent had a job.

- At **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., 83 percent of the residents in the program's second year of operation obtained employment within the required 30 days of entering the program for homeless families, and 60 percent of those who needed a general equivalency diploma (GED) were enrolled in GED classes. Two-thirds of those who completed career training became employed and increased their earnings by 50 percent.

- At **Bridgeway** in Lakewood, Colo., for pregnant and parenting teens, half of the program's graduates not only complete high school but also go on to college or other post-secondary education.

- Ninety-six percent of the mothers in the **Adolescent Mother–Baby Program** graduated from high school or obtained a GED. A fully accredited high school on campus facilitates mandatory school participation.

- Half of the 60 young women in the **Crittenton Hastings House** program between January 1996 and March 1998 have completed high school or received a GED, 10 of whom have gone on to college. Many of the remaining 30 are still attending GED classes or high school.

Decreasing homelessness

Homelessness was a concern for families in all the types of family care programs we surveyed. Significant attention was focused on ensuring families had a place to live when they left.

- **ABC–Rosie & Harry's Place**, for homeless families in New York, conducted monthly assessments of 72 families who had been in the program at least three months. Almost half of the families remained stable or progressed each month, never slipping back. Seventy-two percent of the families transferred to the parent agency's rehousing program or another transitional housing program. The research showed that smaller families tended to make more progress than larger ones and those who moved to transitional housing generally participated longer in the program, on average, 6.9 months.

- At the Prototypes Women's Center, almost half of the clients are homeless upon admission to treatment. At the six-month follow-up, 6 percent of the 124 women studied were homeless.

- **A New Life** in Philadelphia has preliminary findings from a review of women entering drug treatment in 1996–1997, all of whom had been homeless. Thirty-eight of these women and their 41 children lived in transitional housing, about half of them after spending time in mentor homes. On follow-up, 23 were living independently, most in permanent housing. Six of the nine families who lived in mentor homes but did not move to transitional housing also were living independently.

- Homes for the Homeless in New York reports that in 1994 only about 6 percent of participating families returned to the shelter system within two years of graduation. This compares with a 50 percent rate of return among those who leave other city shelters.

- **Harmony House** in Newark, N.J., estimates that 80 percent of participating families complete the program successfully and move on to permanent housing.

- Ninety-one percent of the residents leaving **YWCA Transitional Housing at NIA Terrace** after one year left for permanent housing.

Impact on Children

Family care providers readily enumerate the aspects of family care that they believe make a positive difference for children. First, pregnant women in family care receive prenatal care, which is known to improve birth outcomes. Then, by providing developmental child care—and in some cases therapeutic child care—programs ensure that children are consistently nurtured, stimulated, and treated, not warehoused. The program's continuous oversight and emphasis on peer supports and on parenting helps to ensure children's safety. For many older children, the family care setting is their first safe and nurturing home, the first environment in which the full range of their emotional and physical needs is considered. Finally, children continue to live with their parents, so they are both spared the emotional effects of family separation and benefit from the experience of witnessing their mothers' fight to heal themselves and keep their children. Seeing their parents struggle to maintain and nurture family ties often has a transformative effect on older children, say family care workers. A staff member at **Riel House** in Yakima, Wash., describes the transformation: "We have children come in here who are totally closed and shut down, and we watch them start to open up and totally blossom. They start to smile, start to talk, start to trust . . . they start to heal."

Improving birth outcomes

Family care programs that served pregnant women reported that typically the babies were born drug free and weighed more than babies born to mothers who were not receiving such care.

- CSAT reported in 1995 that 95 percent of the women treated by its women and children's programs' grantees reported uncomplicated, drug-free births.

- At **G.A.P.P. Family Enrichment Center** in Atlanta, of the 12 babies born at the program, all were drug free.

- At the **Integrated Family Treatment Program** in San Antonio, birth outcomes for women with substance abuse problems coming into the program while pregnant were compared with those entering after delivery. Those who entered while pregnant had babies weighing an average of 7 pounds, 6 ounces, whereas the babies of mothers entering after delivery weighed an average of 5 pounds, 14 ounces.

- At **Seton Home,** consistent prenatal care has raised the average birthweight of its young residents' babies to nearly 8 pounds. Similarly, at **Bridgeway**, the average birthweight exceeds 7 pounds, 8 ounces.

Assessing progress of preschool children

Many family care programs we surveyed were improving services for young children. Fewer had data on the impact of their services on the young children's development.

- Project Together, a family care program for parents with substance abuse problems in Des Moines, Iowa, which was not included in our survey, administers the Battelle Developmental Screening Inventory to children at intake, during quarterly reviews, and at program completion. Assessments of 87 children revealed improved scores in each of the functional areas tested (social, motor, cognitive, and communication skills), and these gains persisted through the fourth quarterly review.

- For almost three years, the **Women's Residential Services** substance abuse program administered the Behavior Rating Scale for Children on admission and at discharge to rate children's physical functioning and activity, emotional state, peer relationships, relationships with adults, and any behaviors characteristic of children of alcoholics. All but six of the 48 children tested had significantly lower ratings at graduation than at entry, indicating a substantial reduction in maladaptive behavior.

Assisting school-age children

Changes in school performance are generally used as one indication of the impact of family care on school-age children.

- According to CSAT's 1995 report on its women and children's program's grantees, 84 percent of the children who participated in treatment with their parents improved their school performance.

- At **G.A.P.P. Family Enrichment Center** in Atlanta, serving families with substance abuse problems, program staff reported in early 1997 that of the 37 school-age children served, 100 percent improved in school attendance and study habits, 81 percent improved in academic performance, and 22 children made the honor roll.

- The **Families in Transition** substance abuse treatment program in Miami monitored the 12 children who attended public school for at least one semester while in family care in 1995–1996. According to the director, 60 percent of the children were receiving failing grades at intake. By discharge, all 12 were passing all of their courses, and those who had already been receiving good grades at intake had improved or sustained their performance. In addition, attendance rates increased and tardiness rates fell.

- **YWCA Transitional Housing at NIA Terrace** in Jacksonville, Fla., reported to HUD in October 1997 that all of the children enrolled in its after-school program were promoted to the next grade level, more than the 85 percent originally projected.

Impact on the Mother–Child Relationship

All of the family care programs we surveyed are committed to improving the parent–child relationship and helping the family establish the foundation for lasting family unity. Family care staff believe that a parent's ability to nurture is enhanced by living in a setting where her daily parenting is supervised and where she has the opportunity to learn new parenting skills, not only through parenting education, but also by observing staff as they model good practices in nurturing children.

Promoting parenting skills and emotional attachment

Positive impacts were identified on parenting skills, both on a physical and emotional level, as well as on the mother–child interaction.

- At **Women's Residential Services**, each mother–child relationship was assessed and rated at admission and again at discharge, using the Assessment of Mother–Child Relationships. The assessment addressed physical care, emotional needs and affect, discipline, the mother's involvement with the child, and parenting skills and training. Of the 32 mothers who graduated, 26 showed a statistically significant improvement at discharge, indicating a stronger relationship between mother and child.

- During the course of treatment at **Families in Transition** in Miami, which serves mothers with substance abuse problems, staff measured changes in the level of attachment between mother and child and in the mother's attitudes about her children and her parenting role. Within six months of treatment over the course of FY 1995 and the first half of FY 1996, the levels of attachment between mothers and their children had increased considerably. In addition, there was a significant decrease in the number of parents who considered their children too demanding and difficult.

- Together with Health and Addictions Research, Inc., in Boston, CAPP in Cambridge, Mass., undertook a study for the Center for Substance Abuse Prevention (CSAP) on the impact on parents of a parenting education component in two family care programs not included in our survey. In each program, parents participated in the following activities: a group that focused on children's development; a mothers' support group whose members shared day-to-day experiences; and a 23-week parenting group, where participants worked through a curriculum on nurturing that examined skills and attitudes associated with neglectful and abusive parenting. At discharge, parents in both programs showed significant improvement on the following variables: inappropriate expectations, lack of empathy, corporal punishment, and role reversal.

Facilitating family reunification

Another measure of the impact of family care is the extent to which programs facilitate the safe reunification of parent and child during and following care, or help to safely preserve a family at risk of separation. Although here again data are limited, they suggest that family care facilitates family reunification.

- A look at follow-up data for women served by CSAT's first 11 Residential Women and Children's programs revealed a statistically significant 34 percent increase in the number of cases in which mothers were living with their children from intake to follow-up.

- At the **Families in Transition** substance abuse program in Miami, 95 percent of the women with disrupted families at the time of admission were reunited with their children while in the program.

- Of the families discharged from **Exodus** in Compton, Calif., during the 1996–1997 program year, 41 percent of the clients' children were in their custody compared with 29 percent at admission.

Status at Follow-up

Some family care providers have tried to answer the difficult question of whether the positive impacts of family care persist after families leave the supportive program environment. The few programs that have conducted follow-up research have found that families generally remain intact for at least six months after discharge.

- Six months after discharge, graduates of **Exodus** who had reunited with their children during treatment had no further actions taken against them by child protective services. All of those interviewed also remained drug free. They reported receiving support and treatment from 12-step and self-help programs, family counseling services, and medical services, and reported rejecting friends, spouses, and partners who used drugs or got drunk frequently.
- All women discharged from **Families in Transition** with the sole custody of their children still had their children with them six months later.
- In the 1996 study of 28 of **Project BASTA's** former participants, most who had been away from the program for two months or more had successfully made the transition to independent living. Nearly half had continued some form of education, nearly half were employed, and most had connected with necessary services. The vast majority had experienced no violence or abuse in their relationships since they had left the program and did not use alcohol, drugs, or cigarettes to cope with stress.
- A preliminary analysis of data from CSAT's 11 original grantees under the Residential Women and Children's program showed that women who received aftercare services (such as alcohol and other drug treatment, self-help groups, mental health services, medical services, family counseling, parenting training, educational/vocational services, or employment services) were more likely to be living with their children, employed, and functioning positively than those who did not receive aftercare.

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Chapter 7

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PROMOTING FAMILY CARE TO PROTECT CHILDREN

The challenges involved in providing families facing substance abuse, domestic violence, homelessness, and teen parenting with the treatment and supports they need to nurture and protect their children over the long term are enormous. We wish we could erase all of the problems facing these families and put all our resources into preventing such problems in the future. But since that is impossible, at least in the short run, we have to pursue intervention and prevention agendas simultaneously.

Our survey of family care programs makes us optimistic that the intervention challenge can be met, at least for some families, and that the short- and long-term benefits for children are significant. If communities can provide parents and children with a continuum of services to protect children and improve parents' abilities to nurture and support their children, the younger generation will not re-enact their own parents' histories as adults. To keep children safe and in permanent families, we must take at least the following steps to promote policies and practices that will help heal the whole family.

✓ **Advocates must make a strong case for investments in families coping with substance abuse, domestic violence, homelessness, or the challenges of teen parenting.**

- **The public and policy makers need to hear the stories of parents who have successfully completed comprehensive programs such as family care and are working hard to rear their children responsibly and become fully functioning members of their communities.** Now, both the public and policy makers find it all too easy to write off these families. They are overwhelmed by their problems and doubtful that they can be helped. Although some families cannot be helped, others can. Therefore, to counteract such fatalism, advocates must urge the media to highlight effective programs that invest in treating parents and bolstering the parent–child relationship, which is so critical to the long-term nurturing of the child and stability of the family. Help create opportunities for the media to listen to parents and children who have been helped by these programs. Employers, community leaders, and teachers who see these families succeed can also be vocal advocates on their behalf. It is important to highlight what is required to give more parents similar opportunities for success.

- **The benefits of such programs for both children and parents should be explained**. Highlight the evaluation data that exists about outcomes for both children and parents. Acknowledge that even though not all families want help or can be helped, that helping even a portion of them is an investment that will pay off over time. For example, when parents get the comprehensive help they need, their children are less likely to end up in the child welfare system. By addressing the treatment needs of mothers with substance abuse problems, it is often possible to prevent repeat births by mothers whose children have been placed in foster care.

✓ **Opportunities for families to benefit from family care programs should be expanded**.

- **Continue federal funding for the Residential Treatment Programs for Women and Children and for Pregnant and Postpartum Women for which federal funding has already ended or will end by October 1999**. Support for these programs could continue in a variety of ways. Congress could continue its funding for several more years, recognizing that these programs have not existed long enough to demonstrate their effectiveness. Or Congress could continue funding for only those family care programs that already have both outcome and process evaluations underway. Another option would be to fund these programs jointly through the Children's Bureau and the Center for Substance Abuse Treatment (CSAT) within the U.S. Department of Health and Human Services (HHS) and require that both the state substance abuse treatment and child welfare agencies where the programs are located provide some matching funds.

- **The federal foster care program, authorized under Title IV-E of the Social Security Act, should be amended to allow, as an alternative to foster care for the child, payments for the care of a child placed in family care with a parent who is receiving treatment**. To ensure the safety of the child and the appropriateness of the placement, reimbursement should be provided only when the services are designed to assure the child's safety, appropriately address the needs of both parent and child, increase parenting capacity and skills, and reunite the child with the parent within a specified time period. In addition, the parent must comply with the treatment plan and must not have been previously treated in a family care program. The likelihood of safe and appropriate reunions for parents and children would be significantly increased by such a provision.

- **The Medicaid program should be amended to allow reimbursement for health, mental health, and substance abuse treatment services provided to Medicaid-eligible women and children living in free-standing family care programs that have more than 16 beds**. Current Medicaid law forbids states from using Medicaid to pay for care and treatment provided to individuals between ages 21 and 65 in institutions for mental diseases (IMDs). These institutions include substance abuse treatment programs with more than 16 treatment beds. State officials and family care staff report that the IMD exclusion discourages providers from expanding residential programs for mothers, infants, and older children. Lifting the IMD exclusion, at least for pregnant and postpartum women and other women with children in family care programs with 60 or fewer beds, would help expand available family care programs.

- **Federal and state agencies and private foundations already attempting to alleviate domestic violence, substance abuse, homelessness, and teen parenting should provide joint incentive grants to treatment and service programs that have plans to add comprehensive children's components or strengthen their existing children's programs**. Many of the family care programs we surveyed began by treating only women and later expanded to include children. They described how challenging this transition was. Staff with special skills and expertise in child development must be hired, new services must be developed, special legal issues must be resolved, and new contacts must be made within the community. Special grants for adding or expanding services to reach both young children and older children would be a significant contribution to such programs. The programs should be required to identify a mentor family care program to assist them during the transition.

- **Temporary Assistance for Needy Families (TANF) block grant funds should be used to provide necessary training and other supports to families with substance abuse or domestic violence problems that create barriers to employment**. A strong case can be made for addressing the problems that are preventing families receiving aid under TANF from finding and keeping jobs, as they are required to do under the 1996 welfare law. If parents receive help to overcome these problems, their travels through a maze of public systems will be shorter. At the same time, state welfare agencies will find it easier to comply with federal requirements to place a certain percentage of their TANF caseloads in jobs. Domestic violence programs and substance abuse treatment agencies should work collaboratively with the welfare system and employment and training programs to develop programs, including family care programs, which address these families' needs. Although TANF funds cannot now be used for the medical portions of substance abuse treatment or domestic violence services, they can be used for a range of other essential supports for parents who are in treatment and preparing for or beginning to work. Alone or in collaboration with job training programs, existing family care programs also should receive assistance in developing activities to enhance their clients' job readiness, and these and other eligible activities should be counted as work or community service activities under TANF.

- **A portion of a state's TANF funds should be used to develop second-chance homes for minor parents on welfare who cannot safely live with their parents or other family members**. States should use a portion of their TANF funds to help develop and support family care programs for minor parents and their children who need a supportive living environment but cannot live safely with their own parents or other family members. Collaboration with youth workers and other staff providing independent living services to older youths in foster care will help ensure that second-chance homes include the range of necessary services for children and parents, including help for teens who must complete their education and develop employment skills.

- **Local housing authorities should offer family care programs assistance in identifying funding for housing the treatment programs and for transitional housing and supportive services to help families re-enter their communities**. Almost every family care program CDF surveyed identified lack of housing for program graduates as a barrier to the full realization of its benefits. On the other hand, CDF also heard about local multi-agency efforts to combine services, treatment, and housing. The Departments of Housing and Urban Development (HUD) and HHS should jointly identify such efforts and encourage similar collaborations in other communities.

- **Community organizations and institutions, including religious organizations, volunteer and professional associations, businesses, and colleges and universities should increase in-kind support for family care programs**. Donations of time, expertise, gifts, and supplies for family care programs are no substitute for core operation and program funds. However, they can help to enrich a core program by expanding the range of services and activities that can be provided to parents and children. A community organization might donate a staff person to a family care program to help establish a system for recruiting, screening, training, and supervising volunteers. Churches or other religious organizations, businesses, and associations should adopt specific family care programs and give their members opportunities to assist in a variety of ways in both the administrative and service aspects of the program.

✓ **Efforts to evaluate the impact of family care programs on children and parents and parent–child relationships should be expanded.**

- **Foundations should offer continuing support to family care programs that have evaluation designs in place and work with them to strengthen their assessment of child outcomes, to identify the features of family care that affect specific outcomes, and to assess the cost–benefit of such treatment.** Our family care survey highlighted the need for continuing technical assistance to programs struggling to evaluate their services to parents and children. Some programs have mastered evaluation techniques to assess the impact of treatment for women but are still searching for ways to evaluate the benefits for children. Programs also need help in designing research that will identify the specific features of family care that offer the greatest benefit to children and families and also examine the cost–benefit of such treatment.

- **Foundations should join forces with the Office of the Assistant Secretary for Planning and Evaluation, the Children's Bureau, the Center for Substance Abuse Treatment and other parts of HHS, the office of Victim Assistance in the Justice Department, and other relevant federal offices and agencies to help support effective evaluations and identify the critical components of well-designed evaluations for family care programs just getting underway.** Some of the evaluation components will be transferable across programs that target families facing different challenges, and supplements can address the distinctive features of programs serving different target groups. Within the federal government, this is an opportunity for researchers and program staff to pool knowledge and expertise. This work should be done in consultation with staff of family care programs and researchers with relevant experience.

✓ **In order to protect children effectively, child welfare agencies should increase their capacity to address the needs of parents struggling with substance abuse, domestic violence, and the challenges of homelessness or teen parenting.**

- **Improve assessments of families' strengths and needs.** The treatment and services offered by child welfare agencies must meet the needs of individual families and build on families' strengths. Agency staff must have the expertise necessary to recognize the existence, nature, and extent of families' problems with substance abuse, domestic violence, and/or mental health and must assess the impact of these and other problems on the parents' functioning, their ability to protect and care for their children, the nature of the supports available to them, and the development of their children. Good assessments will require collaborative efforts between child welfare agencies and substance abuse treatment, domestic violence, and mental health programs, as well as programs serving homeless families and teen parents, so that expertise can be shared and staff appropriately trained.

- **Child welfare agencies should collaborate with other service and treatment programs to match families' needs with appropriate services.** To accommodate families' needs, child welfare agencies must begin to provide families with a broader array of supports. Some agencies already seeking to address the needs of multi-problem families have expanded their capacities, and others have collaborated with providers of services for victims of domestic violence, housing authorities, and substance abuse treatment programs to offer more appropriate services. Such partnerships may focus on program design, funding, staffing, and program implementation, or on just one or two of these components. Public and private funders should condition their support on evidence of such partnerships among child welfare agencies, other service and treatment agencies, and community groups.

- **Directly or through collaborative efforts, child welfare agencies should develop staff expertise to give parents the ongoing help they need both during and after treatment, in order to address their underlying problems and devote appropriate attention to effective parenting.** The increased emphasis on permanence and expedited decision-making in child welfare makes it imperative that services and treatment for parents be available as soon as a child enters care, unless danger to the child makes reunification inappropriate. Early treatment will make it more likely that realistic assessments of the likelihood of reunification can be made within the timetables mandated by the Adoption and Safe Families Act. Parents who comply with treatment plans should have access to an array of services and treatment to meet their needs and to ongoing supports after treatment to help them adequately protect and nurture their children. Special attention should be given to the overlapping problems confronting these families. Where possible, cases should be staffed by inter-agency teams. When parents and children cannot live together while receiving services, ongoing support after reunification is essential to ensure that parents do not resume physical custody of their children prematurely, only to find that they are not yet healed and the children must return to foster care. Partnerships with faith communities and other community organizations should be actively encouraged. For families with substance abuse problems, safety plans for children must be in place in the event of a parent's relapse so the children's well-being is protected.

- **Child welfare agencies, together with other relevant agencies and programs, should offer cross-agency and cross-program training for staff working with families challenged by substance abuse, domestic violence, homelessness, or teen parenting.** Joint training of child welfare staff with staff of housing, substance abuse, domestic violence, and teen parent programs will help ensure that child welfare caseworkers understand how these problems affect the families they work with and how they affect parenting and the children in these families. With time, it also will help break down the mistrust that exists among the various service and treatment providers. Cross-training also increases the expertise of staff who work in programs that serve parents at risk of involvement, but not currently involved, with the child welfare system. The training provisions of the Title IV-E Foster Care program should be amended so that the funds can be used for such joint training. A higher match of federal dollars should be available to state agencies or programs that offer joint training. Cross-training also should be an eligibility requirement for federal training funds for staff working with any of these target groups.

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APPENDICES

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APPENDIX A

How CDF Conducted Its Study

With support from the Hite Foundation, the Children's Defense Fund (CDF) undertook the Family Care Research Project to learn more about family care programs and their value in keeping children safe and in permanent families. We studied programs designed to:

- Offer an opportunity for parents and children to live together in supervised living arrangements for an extended period of time.
- Provide comprehensive, individualized services to parents as well as children and to promote family independence and self-sufficiency.
- Focus primarily on families struggling to overcome substance abuse, homelessness, or the problems associated with domestic violence and teen parenting—all problems that threaten family stability and permanency for children.

CDF sought to identify and describe existing family care programs, to better understand their core elements, and to determine how they differ from traditional approaches to ensuring safety and permanence for children and families. Although we attempted to highlight both the similarities and differences among programs serving different target groups in different parts of the country, we did not attempt to evaluate programs or select only model programs.

The project consisted of four major activities:

1. A literature review and annotated family care bibliography. We focused primarily on published scholarly articles discussing the theoretical framework for family care and its effectiveness. We supplemented the literature uncovered by our formal search with resources identified during our survey of national and state organizations (see below), our examination of federal agency activities, and telephone interviews with the staff of family care programs.

2. A survey of national and state organizations. To identify family care programs, we asked for referrals from about 100 national and state organizations we believed were familiar with such programs. These included national organizations advocating on behalf of homeless families, victims of domestic violence, parents with substance abuse problems, teen parents, and children and families at risk of placement with or in the care of child welfare agencies. We also contacted state networks of domestic violence providers, homeless advocates, and multi-issue child advocates.

In addition, we asked for referrals from relevant offices in the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice. In all cases, we asked national organizations to pass along our request to their state and local affiliates. The National Association of Public Child Welfare Administrators sent our letter to all of its state and local child welfare directors. The Children's Bureau in HHS sent our request to its 10 regional counterparts. In addition, we conducted special outreach at several conferences and seminars.

We received the names of more than 400 programs, which had at least some of the characteristics we wanted to study. To refine the list, we conducted a follow-up survey of the initially identified programs, especially those serving victims of domestic violence and homeless families, in order to eliminate those that offered only short-term shelter without services to both parent and child.

3. Telephone interviews of family care programs. CDF wanted to examine programs located in different parts of the country, which would be strong examples of family care and would offer a mix of program designs and budgets, and urban and semi-rural settings. To varying degrees, all of the programs we studied offer residential care for families beyond emergency shelter, therapeutic services to children beyond child care and recreation, and therapeutic services to parents that address the roots of their problems.

Before we conducted the in-depth phone interviews with staff of 56 family care programs, we mailed each prospective interviewee a program questionnaire (see pages A-3–A-8) to help in preparing for the interview. We asked about the program's background, demographics, administration, and funding. The questionnaire also inquired about the nature of the services provided, including aftercare; families' experiences in the program; community supports; program evaluations; and the special challenges and rewards in running such a program. The phone interviews with program staff (supplemented in many cases by follow-up calls and written materials) served as the basis for this report. The family care program staff contact listed in Appendix D is not necessarily the interviewee for the program because program contacts were updated prior to publication.

To assure ourselves of each selected program's good standing in its community, we contacted at least one source familiar to CDF in the city or region where it operates. In addition, we interviewed HHS staff in the Office of the Assistant Secretary for Planning and Evaluation, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment about the selected family care programs they are familiar with. To ensure accuracy in our reporting of the services available in the programs, we asked each program to verify its one-page program summary included in Appendix D. During the course of the study, CDF featured six of the family care programs studied at its national conferences and shared preliminary findings at other meetings, which provided opportunities to learn more about this model of care.

4. Visits to family care programs. We supplemented our telephone survey with site visits to six family care programs. These visits provided us with opportunities to talk with staff members who work directly with children and parents and to interview parents participating in the programs. These voices complemented what we learned from the program directors and administrators in the telephone interviews and helped bring alive the programs for us.

CHILDREN'S DEFENSE FUND
FAMILY CARE PROGRAM QUESTIONNAIRE

Date: Interviewed By:

Respondent:

Name:

Title:

Responsibilities:

Program:

Address:

Phone: Fax:

If different, individual to list in final materials as program contact:

Name: ______________________________

Title: ______________________________

Program: ______________________________

Address: ______________________________

Phone: (__)____________ Fax: (__)____________

Please read through the preceding page of explanation for useful background concerning the survey.

Thank you for your help and willingness to participate in this survey. It is greatly appreciated. Please call Jamila Larson at (202) 662-3574 if you have any questions.

CHILDREN'S DEFENSE FUND
FAMILY CARE PROGRAM QUESTIONNAIRE

Background

1. When did your program begin?

2. Why was the program developed? (In response to what specific problems or needs recognized in the community?)

3. Is your program modeled after a similar program? If so, please specify that program and its location.

4. How many families can your program serve at one time?

5. How many families has your program served since it began?

6. Has your program changed significantly since it began? Please check below and explain.

   ____ Change in size

   ____ Change in population served

   ____ Change in services offered

   Were these changes in response to changing needs of the population you serve? If yes, please describe? Were these changes in response to changes in community? Describe.

Administration

1. Please describe your program's staff. Please include professional, paraprofessional, and volunteer staff, the number of staff in each position, and the duties they perform.

2. What training is provided for staff? By whom? How often?

3. Does your program use volunteers? Who are they (senior citizens, students, etc.)? How are they recruited? How are they used?

4. How is the program governed (Board of Directors, elected representatives)? Who participates in decision-making concerning the program?

5. Are community members, graduates of the program or current program participants involved in program decision-making and governance? (Please specify).

Families Served

1. Who are the families you serve? Do you serve both the mother and the father? How many children do you allow to participate? What is the average age of children served and is there an age limit? Indicate percentage of your population:

   Single parent families________________ One child ________________

   Two parent families ________________ More than one child ________

2. How are families referred to your program?

   Courts ________

   CPS agencies ________

   Word of mouth ________

   Shelter programs ________

   Health clinics ________

   Hospitals ________

3. Are families participating voluntarily? Are they mandated to participate? By whom?

Program Goals

1. What are your program's goals/mission? How were these goals set? Are they reviewed periodically or have they remained the same over time?

Program Services

1. Please describe the housing arrangements for families. (Be specific.) Does a staff member or program representative live on-site with families?

   Discuss specific examples.

   Does each family have its own apartment/housing unit or do multiple families share a housing unit?

   Is it a group living arrangement? If so, do parents and children share a bedroom or are children cared for in a communal nursery with parents sharing bedrooms?

   Do the parent and child live independently or with a foster/supervising family?

   Were the living arrangements specially designed to facilitate interaction between parent–family participants? If so, please describe the design philosophy.

2. Please describe any other on-site program facilities for families (nursery, health clinic, recreational center, etc.).

   EXAMPLES:
   Counseling centers?
   Child care?
   Educational facilities?
   Job search/training facilities?
   Visiting areas?

3. Please list the specific services available for parents, for children, and the family as a unit. Which services are provided on-site? Which services are provided off-site and where?

4. If your program serves primarily single parent families, what efforts if any are made to involve the non-custodial parent (except in cases where such contact may jeopardize the safety of the custodial parent or child)?

5. How are decisions made concerning what services family members will receive?

6. What assessments are conducted of families' strengths and weaknesses and by whom?

Completing the Program

1. What requirements must be met by families to initially participate in your program? To continue in your program? Please check below and describe. What are the consequences of not complying?

   ____ Financial eligibility   ____ No drugs or alcohol

   ____ Parent(s) participation in work or job training

   ____ Parent(s) participation in school or work toward GED

   ____ Parent(s) participation in program activities (please specify.)

   ____Other?

2. What is the minimum length of stay with your program? The maximum length of stay? What is the average length of stay in your program?

3. How is a family's progress tracked? What incentives are there for families to reach their goals? Does this vary throughout the stages of the program?

4. Who determines when a family is ready to leave the program?

5. What proportion of the families you have served have successfully completed the program?

6. Generally, where do families live after they leave your program? Do they move into transitional housing? permanent housing?

7. What percentage of the families who complete your program remain intact? Over what period of time? (E.g., six months after completion? one year after completion?)

8. What aftercare services/supports do you provide to the families?

9. Do you maintain contact with the families after they leave your program? How?

10. Please describe a family who has recently benefited from your program.

11. Please describe a family who did not successfully complete the program, and describe the problems the family encountered.

12. What percentage of families who begin the program fail to complete it? What percentage of families decide to drop out? At what stage is dropout most common? For example, do families tend to drop out early in the program? If a family stays in the program for the first two weeks/three weeks/four weeks are they very likely to successfully complete the program?

Family Life

1. Who has primary care-taking and decision-making responsibility for the child while the family is in your care? If it differs, please describe.

2. What does the family do during the time that services are not being provided to either the parent or the child? Is this time structured?

Evaluation

1. What evaluations have there been of your program? Please specify for each: 1) the major findings of the evaluations; 2) who carried out the evaluation; and 3) how the evaluation was funded.

2. If no evaluation has been completed to date, are any evaluations underway? Do you have plans for evaluations? If any, please describe.

3. What replications have there been of your program?

4. Would you like to see your program replicated? What do you believe are the barriers to doing so?

Funding Sources

1. What is your annual operating budget?

2. What percentage of your funding derives from federal resources? state? local? foundations? businesses? religious organizations? other? (Please specify.) Is funding from demonstration projects or on–going grants? How often do funding sources require re–application?

3. What is the average cost per family per year? Please list the major components of that cost.

4. What in-kind donations or free services do you receive from the community? If so, please detail.

5. What additional funding sources would you like to see made available to your program?

Challenges and Rewards

1. What would you say are the three greatest challenges you face in administering your program? (This may include problems with funding, clients, service provision, etc.)

2. What are the most frequent complaints about your program among the families you serve?

3. What are the special challenges created by caring for parents and children together?

4. What do you consider to be the benefits of caring for parents and children together?

5. What accounts for the success of your program?

6. What plans, if any, do you have for expanding your program? What do you see as the barriers to program expansion?

7. Is the size of your facility adequate to meet the needs for such services in your community? How long is your waiting list?

Additional Information

1. Would it be possible to visit your program? When might be a convenient time?

2. Are you willing to allow us to contact any graduates of your program? Would you be willing to send us any letters or other testimonials about the program from families you have served?

   Is there anything else we should know to better understand how your program works?

THANK YOU!

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APPENDIX B

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Selective Annotated Bibliography on Family Care and Related Issues

Bailey, D. B., Buysse, V., Edmondson, R., & Smith, T. M. (1992). Creating Family-Centered Services in Early Intervention: Perceptions of Professionals in Four States. *Exceptional Children, 58* (4), 298–309.

Describes some of the challenges involved in implementing a family-centered approach to early intervention services. Reports on a four-state survey of about 180 early intervention professionals, undertaken to identify professional perceptions of discrepancies that exist between existing family involvement practices and ideal best practices and the reasons for those discrepancies. Useful in understanding the steps necessary to achieve benefits from family-centered approaches to service delivery in varied settings.

Barth, R. P. (1993). Shared Family Care: Child Protection Without Parent–Child Separation. In R. Barth, J. Pietrzak, & M. Ramler (Eds.), *Families Living with Drugs and HIV: Intervention and Treatment Strategies* (pp. 272–295). New York: Guilford Press.

Effectively uses program examples from the United States and Sweden to describe different models of shared family care, with specific emphasis on how these programs respond to the needs of substance-involved families. The importance of shared family care's home-like setting, innumerable teachable moments, and opportunities for structure and community integration are detailed. Includes recommendations for the development of shared family care for drug-involved women and their children.

Barth, R. P. (1994). Shared Family Care: Child Protection and Family Preservation. *Social Work, 39* (5), 515–524.

Provides a useful discussion of the rationale for shared family care, as well as descriptions of five types of such care that have evolved to keep parent and child together. The fullest attention is given to shared family care, in which foster homes offer care of parent and child. Specific programs are referenced for each type of care. Makes a compelling case for shared family care for families who do not benefit from in-home family preservation services.

Breyel, J. M., & Hill, I. T. (1993). *Creating Systems of Care for Substance-Using Pregnant Women and Their Children.* Washington, DC: National Governors' Association.

Presents findings from a National Governors' Association survey identifying the scope and nature of state and federal efforts to meet the needs of substance-using pregnant women and their children. Discusses the impact of perinatal substance abuse and the role of the state and federal governments in the current treatment system. Highlights 10 model states whose coordinated efforts have established a multi-agency response to the problem of perinatal substance abuse.

Camp, J. M., & Finkelstein, N. (1997). Parenting Training for Women in Residential Substance Abuse Treatment: Results of a Demonstration Program. *Journal of Substance Abuse Treatment, 14* (5), 411–422.

Presents findings on the impact of a parenting component in two urban residential treatment programs in Massachusetts on outcomes for pregnant and parenting chemically dependent women and their infants. The parenting component was part of a five-year service demonstration project for the Coalition on Addiction, Pregnancy and Parenting, in Cambridge, Mass. Researchers concluded that parenting skill training should be considered an important part of residential substance abuse treatment for pregnant and parenting women.

Coletti, S. D., Schinka, J. A., Hughes, P. H., Hamilton, N. L., et al. (1995). PAR Village for Chemically Dependent Women. *Journal of Substance Abuse Treatment, 12*, 289–296.

Describes the operation and structure of PAR Village, a therapeutic community for chemically dependent mothers and their children in St. Petersburg, Fla. Discusses the challenges and benefits of residential treatment for these women. Details PAR Village's client selection process, program philosophy, and the services and specialized treatment elements offered by the program that are considered especially important.

Cornish, J. (1992). Fostering Homeless Children and Their Parents Too: A Unique Approach to Transitional Housing for Homeless Families. *Community Alternatives: International Journal of Family Care, 4* (2), 43–59.

Traces the adaptation of specialized foster care, previously used for young mothers and babies, to meet the needs of homeless parents and their children. Describes a transitional housing program run by Human Services Associates in Minnesota, which is staffed by intensively trained host families with the personal experience of homelessness or poverty. The program serves families that need more than housing to enable them to move beyond the struggle for survival, nurture their children, and gain control of their lives. Details the importance of training, research, and evaluation in overall programming.

Dvorchak, P. A., Grams, G., Tate, L., & Jason, L. A. (1995). Pregnant and Postpartum Women in Recovery: Barriers to Treatment and the Role of Oxford House in the Continuation of Care. *Alcoholism Treatment Quarterly, 13* (3), 97–107.

Discusses the barriers pregnant and postpartum women face in attempting to recover from alcohol and substance abuse and describes how the Oxford House model proposes to address those barriers. The Oxford House model is a self-supportive, long-term aftercare model, which combines the traditional 12-step program from alcoholism

treatment and the concepts of a self-directed community. Oxford Houses, the authors assert, offer an important alternative for long-term support and a secure family environment for women with their children. They suggest that the most successful houses have combined some women residents with children and some without.

Dydyk, B. J., French, G., Gertsman C., Morrison N., & O'Neill, I. (1989). Admitting Whole Families: An Alternative to Residential Care. ***Canadian Journal of Psychiatry, 34*** **(7), 694–699.**

Describes the Intensive Family Therapy Unit, established as part of the Canadian Residential Treatment Center for Children and Adolescents, as an alternative to the institutionalization of children with serious emotional disturbances. Whole families are admitted for short-term intensive assessment and treatment. The opportunities provided by the observation assessment, especially in the case of the more dysfunctional families, are similar to those underlying other family care programs. As in similar family care settings, the treatment team builds on the parent's strength and offers specific follow-up treatment strategies.

Finkelstein, N. (1995). Treatment Programming for Alcohol and Drug-Dependent Pregnant Women. ***International Journal of the Addictions, 28*** **(13), 1275–1309.**

Describes the barriers to adequate care for pregnant women and women with young children in need of chemical dependency treatment. Includes a list of six guiding principles for services for these women and their children. Describes the components of a comprehensive treatment model for pregnant and parenting chemically dependent women. Unresolved policy issues and recommendations for future research are identified.

Gabinet, L. (1983). Shared Parenting: A New Paradigm for the Treatment of Child Abuse. ***Child Abuse and Neglect, 7,*** **403–411.**

Argues for improving parental functioning as a means of alleviating child abuse and other forms of child deprivation. Proposes a model of "shared parenting," whereby outside providers augment rather than supplant parental care. Parents provide as much of the care of their children as they are able. Highlights the principles that underlie many family care programs and establishes family care as part of a continuum of other family support programs.

Gibson, D., & Noble, D. N. (1991). Creative Permanency Planning: Residential Services for Families. ***Child Welfare, 70*** **(3), 371–382.**

Explores the residential family program as a creative approach to permanency planning. Describes the Family Cottage, operated by the Texas Baptist Children's Home, which addresses families' financial and housing needs; abuse and other dysfunction; the risks of family separation; and ineffective parenting resources and skills. Discusses the importance of parental involvement and family support in the treatment process for children.

Gibson, J. W., & Gutierrez, L. (1991). A Service Program for Safe-Home Children. ***Families in Society: The Journal of Contemporary Human Services,*** **554–561.**

Describes an exploratory study of the Safe Homes Program, which has established a network of community safe homes in which host families shelter battered women and their families and provide services to both the children and the mothers. Reviews the research on children of battered women to demonstrate the need to give greater attention to the complex needs of these children. Discusses the most basic components of necessary services for children who accompany their mothers to shelters, as well as the need for specific attention to the women as parents.

Hanson, S. L. (1992). Involving Families in Programs for Pregnant Adolescents: Practices and Obstacles. ***Families in Society: The Journal of Contemporary Human Services*, 274–281.**

Reports on data from a national descriptive study of family involvement strategies used in programs for pregnant teens funded under the Adolescent Family Life Programs. The study documents that the programs offer little family involvement, even though staff attitudes toward family involvement are positive. Describes the barriers to family involvement and indirectly suggests why difficulties are to be expected when principles from family care are applied to nonresidential services.

Hughes, P. H., Coletti, S. D., Neri, R. L., Urmann, C. F., et al. (1985). Retaining Cocaine-Abusing Women in a Therapeutic Community: The Effect of a Child Live-In Program. ***American Journal of Public Health, 85*** **(8), 1149–1152.**

Discusses an evaluation that examined whether retention rates of cocaine-abusing mothers in a therapeutic community can be improved by allowing their children to live with them during treatment. Fifty-three women were randomly assigned to either a control or demonstration group at Operation PAR in Florida. Children of mothers in the control group lived with the best available caretaker outside the therapeutic community and visited the mother no more than three times a week. The evaluation found that women who lived with their children during treatment remained significantly longer than those who did not. Good discussion of methodology and findings.

Knitzer, J., & Yelton, S. (1990). Collaborations Between Child Welfare and Mental Health. ***Public Welfare,*** **24–47.**

Explores the rationale for cross-system collaboration between child welfare and mental health systems. Provides examples of state and local collaboration activities, discusses the barriers to implementing collaborations, and suggests possible strategies for overcoming these barriers. The trends described provide useful background for discussions of family care in states and communities. Recommendations for providing effective and responsive services to at-risk children and families are transferable to other kinds of services and cross-system collaborations.

Luthar, S. S., & Walsh, K. G. (1995). Treatment Needs of Drug-Addicted Mothers: Integrated Parenting Psychotherapy Interventions. ***Journal of Substance Abuse Treatment, 12,*** **341–348.**

Examines the psychological risks facing addicted mothers and gender-based theories of development as a basis for developing an effective integrated treatment approach for drug-abusing mothers and their children. Concludes that the components of such a model would include parent education and training, supportive psychotherapy, and gender sensitive interventions.

McMahon, T. J., & Luthar, S. S. (1998). Bridging the Gap for Children as Their Parents Enter Substance Abuse Treatment. In R. L. Hampton, V. Senatore, & T. P. Gullota (Eds.), *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives* (pp. 143-187). Thousand Oaks, CA: Sage Publications.

Explores what can be done within drug abuse treatment systems to develop services that directly affect the quality of life for children living with a drug-dependent parent. Describes the gaps that exist in our ability to intervene effectively on behalf of children affected by parental substance abuse. Examines what is known about substance abuse, its impact on family life and on children's development. Outlines the structural components and other considerations that need to be developed and addressed within drug treatment programs to meet the needs of parents and children and the evolving models of family-oriented substance abuse treatment, including residential treatment for women and their children.

Metsch, L. R., Rivers, J. E., Miller, M., Bohs, R., et al. (1995). Implementation of a Family-Centered Treatment Program for Substance-Abusing Women and Their Children: Barriers and Resolutions. *Journal of Psychoactive Drugs, 27* (1), 73–83.

Reports on the start-up months of the Village South Families in Transition Program in Miami, funded by the federal Center for Substance Abuse Treatment and the Ounce of Prevention Fund in Florida. Describes the challenges involved in securing a facility for women and children, hiring and training staff, establishing and maintaining community ties and balancing treatment goals with evaluation goals. Includes a useful discussion of some specific decisions the program had to make as it was getting started. The issues discussed include child care, overnight visits, and custody arrangements for the children of parents in care, provision for the care of the children when the parent is ill or is expelled from the program, and the handling of child abuse and neglect reports.

Murray, L. (1992). Critical Issues in Residential Care for Young Mothers and Infants: An Overview of Model Licensing Rules. *Child Welfare, 71* (2), 157–163.

Describes how state licensing agencies can help ensure that the special needs of young parents and their children are met in residential programs for pregnant and parenting adolescents. The model licensing requirements discussed address the qualifications, supervision, and training of staff; staff–client ratios; program and health requirements geared toward the adolescent as an individual and mother; and services to fathers. Model rules pertaining to infant stimulation, experiential parenting education, and involvement by fathers also are discussed.

Nayman, L., & Witkin, S. L. (1978). Parent/Child Foster Placement: An Alternate Approach in Child Abuse and Neglect. *Child Welfare, 57* (4), 249–258.

Uses a case study to illustrate the challenges involved in developing and maintaining a parent–child foster placement designed to strengthen parental functioning in a sheltered family environment. Demonstrates the value of such a model in assessing and effectively facilitating parent–child interactions in families where there has been abuse or neglect. Describes briefly where this model sits in the continuum of family preservation and family care programs. Suggests exploring the treatment implications of parent–child foster placements.

Nelson, K. M. (1995). Foster Care . . . Not Just for Kids Anymore: Use of Whole Family Placement to Reunite Substance-Abusing Parents with Their Children. *The Source, 5* (1), National Abandoned Infants Assistance Resource Center, 1, 3–5, 12.

Describes the evaluation of Whole Family Care at Minnesota Human Services Associates as an option for families involved in child protective systems as a result of parental use of crack cocaine. After its earlier use with homeless families, the model has been adapted for drug-involved families to avert children's placement in foster care or to facilitate family reunification. The client family lives with a host family and receives essential services, including family life and parenting education, respite child care, and counseling and support. Discusses the key program components and the challenges involved in expanding the use of the model for these families and others. Also examines the criteria by which the program judges its success.

Price, A. (1994). A Safe and Sober Home—An Integral Part of the Recovery Process. *The Source, Reprint 11* (1), National Abandoned Infants Assistance Resource Center.

Traces a continuum of residential programs for recovering women with children that includes inpatient treatment programs, transitional housing, and permanent housing. All of the programs are designed to address the women's housing and treatment needs and to keep their children with them. Argues that each type of program, but especially permanent housing, must be linked to available support services in the community. Discusses structural and programmatic issues pertaining to residential programs, as well as collaboration and financing concerns that must be addressed in starting them. Program examples are plentiful.

Price, A., & Barth, R. P. (1996). *Shared Family Care Program Guidelines.* Berkeley, CA: National Abandoned Infants Assistance Resource Center, School of Social Welfare, University of California at Berkeley.

Developed with the assistance of the Shared Family Care Technical Expert Group, this manual is intended to guide state and local organizations and private community-based agencies wishing to incorporate shared family care into their continuum of services. Describes the potential uses of shared family care as a service option, core elements of the approach, issues related to choosing and supporting host families, licensing and liability issues, and evaluating and financing such programs. Includes samples of program materials and suggested evaluation instruments.

Rahdert, E. (Ed.). (1996). *Treatment for Drug-Exposed Women and Their Children: Advances in Research Methodology* (NIH Publication No. 96–3632). Washington, DC: National Institute on Drug Abuse (NIDA) Research Monograph Series, No. 166.

This volume presents lessons learned from the treatment programs for drug-abusing pregnant and postpartum women and their infants funded by the National Institute of Drug Abuse's Perinatal-20 Treatment Research Demonstration Program. Data and experiences from both residential and nonresidential treatment programs are discussed in the following areas: program implementation and treatment research, subject selection, recruitment, retention, measurement, and data management and analyses. An article by Peggy Glider et. al. describes how two therapeutic communities, Amity, Inc., in Tucson, Ariz., and Operation PAR in St. Petersburg, Fla., developed

randomized clinical trials to test the hypothesis that admitting substance-abusing women with their children to treatment would improve retention and long-term outcomes.

Rosensweig, M., Greenberg, R., Lyon, K., & Kroner, S. (1996). ***From the Source: A Guide for Implementing Perinatal Addiction Prevention and Treatment Programs. A CSAP Implementation Guide.*** **Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.**

Offers step-by-step advice for creating or improving substance abuse prevention and treatment programs for pregnant and parenting women. Draws on the expertise of the first 115 Pregnant and Postpartum Women and Their Infants Demonstration Programs funded by the Center for Substance Abuse Prevention in 1989 and 1990. The advice is applicable to a wide range of treatment models, and it includes useful suggestions for addressing parenting issues. A short essay in the appendix by Norma Finkelstein, director of the Coalition on Addiction, Pregnancy and Parenting, argues that programs providing coordinated, comprehensive, and family-centered care are more likely than other types of programs to attract pregnant and parenting substance-abusing women into treatment and provide more effective treatment.

Saunders, E. J. (1993). A New Model of Residential Care for Substance-Abusing Women and Their Children. ***Adult Residential Care Journal, 7*** **(2), 104–117.**

Describes Project Together, a family care program for substance-abusing women and their children started in Des Moines, Iowa, in 1990. The project is described in the context of a general discussion of the complex needs of chemically dependent women. Uses a detailed report on the gains made by both mothers and children on exit from the program to demonstrate the value of the family care model. Notes that lack of significant positive changes among women on the parenting measure resulted in the adoption of a structured parenting curriculum.

Sprague, J. F. (1991). ***More Than Housing: Lifeboats for Women and Children.*** **Boston: Butterworth Architecture.**

A resource for the design, planning, and programming of a range of supportive living arrangements for homeless families that need more than housing assistance. Includes examples of family care and other programs nationwide and describes how residents, sponsoring agencies, advocates, and architects can work together to integrate social and economic supports within housing to promote family stability.

Stark, E., & Flitcraft, A. H. (1988). Women and Children at Risk: A Feminist Perspective on Child Abuse. ***International Journal of Health Services, 18*** **(1), 97–118.**

Examines the relationship between woman battering and child abuse. Reports on a study of children suspected of being abused and neglected that traces the violence between their parents. The study documents the disproportionate likelihood that abused children will be removed from battered mothers. Outlines some of the evidence and rationale that underlie increased attention to family care within the shelter movement for victims of domestic violence.

Stevens, S. J., & Arbiter, N. (1995). A Therapeutic Community for Substance-Abusing Pregnant Women and Women with Children: Process and Outcome. *Journal of Psychoactive Drugs, 27* (1), 49–56.

Provides an overview of the national crisis of pregnant women and mothers who are chemically dependent. Discusses co-occurence of substance abuse, a history of child abuse, and domestic violence. Profiles the Amity Center for Women and Children in Tucson, Ariz., a family care program, and documents the link between longer lengths of stay and better outcomes for residents. Presents demographic information on the families served.

Sylvester, K. (1995). *Second-Chance Homes: Breaking the Cycle of Teen Pregnancy.* Washington, DC: Progressive Policy Institute. (Policy Briefing).

Proposes the establishment, with federal support, of a national network of second-chance homes to help provide teen mothers the nurturing and support, structure, discipline, and socialization they need. Describes the roots of such family care homes in the maternity homes of old. The discussion of the elements of successful homes and their achievements is drawn from examples of residential treatment centers for pregnant teens, which are then described in more detail in the appendix.

VanBremen, J. R., & Chasnoff, I. J. (1994). Policy Issues for Integrating Parenting Interventions and Addiction Treatment for Women. *Topics in Early Childhood Special Education, 14* (2), 254–274.

Explores the challenges involved in integrating parenting interventions with substance abuse treatment. Provides a rationale for offering these two critical interventions in tandem and describes the conflicts inherent in the relationship. The experiences in integrating maternal and child services in a number of residential and outpatient treatment programs initiatives are reviewed, namely the National Association for Perinatal Addiction Research and Education's Family Recovery Center in Chicago. Offers program guidelines for parenting agencies developing interventions for parents who are addicted and their children.

Wobie, K., Davis Eyler, F., Conlon, M., Clarke, L., & Behnke, M. (1997). Women and Children in Residential Treatment: Outcomes for Mothers and Their Infants. *Journal of Drug Issues, 27* (3), 585–606.

Examines at the Women's Residential Treatment Center in Orlando, Fla., the relationship between the living arrangement of mother and baby and the mother's self-esteem, depression, parental competence, length of stay, and completion or noncompletion of treatment. Findings revealed that the earlier an infant joins the mother in the program, the longer her length of stay will be, with an increased opportunity for program completion. Women who had their infants living with them also remained in treatment longer than those who did not. They also had significantly lower mean depression scores and significantly higher mean self-esteem scores than those not living with their mothers in treatment.

Wood, P. E. (1991). Residential Treatment for Families of Maltreated Children. ***Child Welfare, 60*** **(2), 105–108.**

Describes an early whole family residential program operated by Blosser Home for Children in Marshall, Mo., for families in which preschool children had been mistreated, but there was no serious substance abuse, family violence, or mental illness. The program was rooted in the belief that parental behavior is most effectively changed if parents and children live together in a supervised supportive environment with services. Lists the activities and services provided in the program.

Zimmer, R., & Schretzman, M. (1991). Issues for Homeless Women and Their Children. In P. Roth (Ed.), ***Alcohol and Drugs Are Women's Issues, Volume One: Review of the Issues*** **(pp. 173–177). Metuchen, NJ: Women's Action Alliance and Scarecrow Press, Inc.**

Chronicles the increase in the population of homeless women and children, as well as the inadequacy of the service response. The needs of women with alcohol or other drug problems are given special attention. Makes a case for a holistic approach to treating these women, incorporating shelter, chemical dependency rehabilitation, family–child treatment, and medical services. Emphasizes the need for equal care in treatment planning for the children of addicted homeless women.

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APPENDIX C

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Selected Characteristics of Family Care Programs Studied by CDF

(as of date interviewed)

Family Care Programs Studied by CDF	Location	Year Began	Capacity (in families)	Setting	Average Length of Stay (in months)	Annual Budget	Funding (% public / % private)
Substance Abuse							
Casa Rita	New York	1986	16	Group house	12	$1,600,000	100 / 0
Comprehensive Treatment Services	Newton, Kan.	1990	12	Group house	6	$500,000	100 / 0
Exodus	Compton, Calif.	1994	50	Apartments	12–24*	$1,200,000**	100 / 0
Families in Transition	Miami	1992	20	Apartments	10	$1,000,000	100 / 0
First Step Home	Cincinnati	1990	12	Group house	8*	$586,000**	59 / 41
Flint Odyssey House, Inc.	Flint, Mich.	1990	20	Group house	12*	$850,000**	90 / 10
Flowering Tree	Pine Ridge, S.D.	1992	10	Group house	12	$660,000	100 / 0
G.A.P.P. Family Enrichment Center	Atlanta	1994	20	Group house	6	$1,000,000	98 / 2
Grace Hill	St. Louis	1994	14	Group house	12	$670,000	100 / 0
Hutchinson Place	Philadelphia	1995	20	Group house	9	$900,000	95 / 5
Integrated Family Treatment Program	San Antonio	1993	27	Group house	6	$1,400,000	100 / 0
A New Life	Philadelphia	1991	35	Shared family home	6–9*	$563,000**	100 / 0
PAR Village	Largo, Fla.	1990	57	Group house	10	$1,200,000	100 / 0
Positive Images	Detroit	1987	25	Group house	3	$472,000	90 / 10
Pregnant & Postpartum Women & Infants Program	Chicago	1993	16	Group house	6*	$1,046,000**	100 / 0
RBHA—Recovering Families Project	Richmond, Va.	1994	14	Group house	7*	$950,000**	100 / 0
Riel House	Yakima, Wash.	1990	14	Group house	6	$1,811,000	86 / 14
St. Martin's House	Washington, D.C.	1990	[illegible]	Group house	6	$355,000	80 / 20
Women & Children's Residential Program	Fairbanks, Alaska	1994	[illegible]	Group house	6*	$775,000**	100 / 0
Women's Residential Services	Libertyville, Ill.	1986	15	Group house	2–3	$899,600	99.5 / 0.5
Women's Way	Honolulu	1982	[illegible]	Group house	6	$1,645,000	93 / 7
Woodsong	Thomasville, Ga.	1994	[illegible]	Group house	9–12*	$930,000**	85 / 15

Family Care Programs Studied by CDF	Location	Year Began	Capacity (in families)	Setting	Average Length of Stay (in months)	Annual Budget	Funding (% public / % private)
Domestic Violence							
Domestic Abuse Family Shelter	Laurel, Miss.	1984	20 (people)	Group house	2*	$223,000**	100 / 0
Domestic Violence Intervention Services, Inc.	Tulsa, Okla.	1976	22	Group house	1*	$1,400,000**	58 / 42
Family Sunshine Center	Montgomery, Ala.	1981	12	Group house	3–4	$380,347	100 / 0
HerSpace	Washington, D.C.	1977	6	Group house	2*	$297,000**	62 / 38
HerStory House	Rutland, Vt.	1979	8	Group house	1*	$180,000**	80 / 20
Middle Way House	Bloomington, Ind.	1971	30 (people)	Group house	1*	$287,000**	73 / 27
Project BASTA	Boston	1992	16	Group house	14	$675,000	81 / 19
The Rainbow/The Ark	Gary, Ind.	1976	7	Group house	0.5*	$250,000**	95 / 5
Rainbow House	Chicago	1982	25	Group house	2	$1,000,000	50 / 50
Women Helping Battered Women	Burlington, Vt.	1974	6	Group house	1	$300,000	50 / 50
Homelessness							
ABC—Rosie & Harry's Place	New York	1986	13	Apartments	6	$600,000	100 / 0
Casa Loma	Los Angeles	1993	110	Apartments	72–120	$500,000	20 / 80
Greentree Shelter	Bethesda, Md.	1983	15	Group house	3***	$827,000***	85 / 15
Harmony House	Newark, N.J.	1989	102	Apartments	8	$2,500,000	100 / 0
Rose McCarthy Family Residence	New York	1994	36	Apartments	9	$1,100,000	100 / 0
Saratoga, Island, Prospect, & Clinton Family Inns	New York	1986	540 (in 4 programs)	Apartments and group homes	7–8	$15,000,000 (for 4 programs)	95 / 5
Virginia Place	Lexington, Ky.	1986	55	Apartments	36	$633,000	89 / 11
Warren Village	Denver	1974	94	Apartments	19	$2,000,000	47 / 53
YWCA Transitional Housing at NIA Terrace	Jacksonville, Fla.	1995	58	Apartments	12	$480,000	100 / 0

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Family Care Programs Studied by CDF	Location	Year Began	Capacity (in families)	Setting	Average Length of Stay (in months)	Annual Budget	Funding (% public / % private)
Pregnant & Parenting Teens							
Adolescent Mother–Baby Program	Hyattsville, Md.	1983	14	Group house	24*	$650,000**	98 / 2
Bridgeway	Lakewood, Colo.	1986	25	Group house	8	$300,000	25 / 75
Crittenton Hastings House	Boston	1995	20	Group house	12–24	$800,000	100 / 0
Crittenton Programs, Inc.	Wheeling, W. Va.	1886	28	Group house	9	$1,500,000	100 / 0
New Empowerment Alternatives	Trenton, N.J.	1986	12	Group house	7*	$917,000	69 / 31
Seton Home	San Antonio	1981	16	Group house	10**	$350,000**	39 / 61
Teen Parenting Services	Portland, Maine	1991	7	Apartments	18	$111,000	100 / 0
Therapeutic Foster Families	Chicago	1985	18	Shared family home	not available*	$335,000**	95 / 5
Ujima House, Inc.	Phoenix	1995	4	Group house	12	$80,000	0 / 100

*Transitional housing is available beyond the average stay.

**Annual budget figures exclude transitional housing costs.

***Transitional housing is available beyond the average stay, but the cost of it is excluded from the annual budget figure. Generally, in the other homeless programs we surveyed, the programs themselves were considered as transitional housing.

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APPENDIX D

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Family Care Program Summaries

ABC—Rosie & Harry's Place

Address: 419 East 86th Street
New York, NY 10028
Phone: (212) 831-1322
Contact name: Gretchen Buchenholz, Executive Director
Parent agency: Association to Benefit Children (ABC)
Primary problem addressed: Homelessness
Year began: 1986
Capacity: 13 families
Setting: Individual apartments
Average length of stay: 6 months
Aftercare: Periodic phone checks
Annual budget: $600,000
Funding source: **Public:** Federal: 0%; State: 0%; Local: 100%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services		Separate assessment
x	Health education and nutrition		Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy	x	Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 5/16/96

Adolescent Mother–Baby Program

Address: 4901 Eastern Avenue
Hyattsville, MD 20782
Phone: (301) 559-5500
Contact name: Lisa Boyle, Director of Social Services
Parent agency: St. Ann's Infant & Maternity Home
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1983
Capacity: 14 families
Setting: Group house
Average length of stay: 2 years
Aftercare: Transitional housing
Annual budget: $650,000 *(excluding transitional housing costs)*
Funding source: Public: Federal: 0%; State: 69%; Local: 29%; **Private:** 2%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
x	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 3/29/96

Bridgeway

Address: 85 South Union Boulevard
Lakewood, CO 80228
Phone: (303) 969-0515
Contact name: Richard Haas, Executive Director
Parent agency: Same as program
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1986
Capacity: 25 families
Setting: Group house
Average length of stay: 8 months
Aftercare: Periodic phone checks
Annual budget: $300,000
Funding source: **Public:** Federal: 25%; State: 0%; Local: 0%; **Private:** 75%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents
x	Health services
x	Health education and nutrition
x	Physical exercise
	Self-defense
x	Life skills
x	Education/job preparation
x	Job placement
	Legal advocacy
x	Substance abuse assessment
	Substance abuse treatment
	Self-help group (AA/NA)
x	Therapy for sexual/domestic abuse
x	Self-esteem building/self-awareness
x	Interpersonal skills/conflict resolution
	Art therapy
	Services for Other Family Members
	Men's group
x	Family group with nonresidents
	Batterers' program

	Children
	Separate assessment
x	Child health services
	After-school program
	Academic tutoring
	Summer day camp
	Individual counseling
	Therapeutic or developmental child care
	Crisis nursery for respite care
	Self-esteem building
	Conflict resolution/socialization
	Children of survivors group
	Personal safety/body rights group
	Teen support group
	Parent–Child
x	Assessment of parent–child relationship
	Family therapy
x	Supervised parent–child interaction
x	Organized recreation

As of 11/13/95

Casa Loma

Address: 379 South Loma Drive
Los Angeles, CA 90017
Phone: (213) 483-2060
Contact name: Maggie Cervantes, Executive Director
Parent agency: New Economics for Women
Primary problem addressed: Homelessness
Year began: 1993
Capacity: 110 families
Setting: Individual apartments
Average length of stay: 6–10 years
Aftercare: Regular follow-up with an aftercare worker
Annual budget: $500,000
Funding source: **Public:** Federal: 20%; State: 0%; Local: 0%; **Private:** 80%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. in addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition		Child health services
x	Physical exercise	x	After-school program
x	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 8/14/96

Casa Rita

Address: 292 East 151st Street
Bronx, NY 10451
Phone: (718) 402-0066
Contact name: Sharon L. Dorr, Program Director
Parent agency: Women in Need, Inc.
Primary problem addressed: Substance abuse
Year began: 1986
Capacity: 16 families
Setting: Group house
Average length of stay: 1 year
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $1.6 million
Funding source: Public: Federal: 40%; State: 30%; Local: 30%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services		Separate assessment
x	Health education and nutrition		Child health services
x	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents		Organized recreation
	Batterers' program		

As of 3/5/96

Comprehensive Treatment Services

Address: P.O. Box 711
Newton, KS 67114
Phone: (316) 283-7449
Contact name: Roy Anne Post, Vice President of Treatment Services
Parent agency: The Mirror
Primary problem addressed: Substance abuse
Year began: 1990
Capacity: 12 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $500,000
Funding source: **Public:** Federal: 60%; State: 20%; Local: 20%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		Children
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 7/22/96

Crittenton Hastings House

Address: 10 Perthshire Road
Boston, MA 02135
Phone: (617) 782-7600
Contact name: Robin Finnegan, Director of Housing
Parent agency: Same as program
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1995
Capacity: 20 families
Setting: Group house
Average length of stay: 1–2 years
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $800,000
Funding source: **Public:** Federal: 50%; State: 50%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse		Personal safety/body rights group
	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents		Organized recreation
	Batterers' program		

As of 1/17/97

Crittenton Programs, Inc.

Address: 2606 National Road
Wheeling, WV 26003-5393
Phone: (304) 242-7060
Contact name: Cathy Szafran, Vice President of Residential and Medical Services
Parent agency: Florence Crittenton Services, Inc., of West Virginia
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1886
Capacity: 28 families
Setting: Group house
Average length of stay: 9 months
Aftercare: Continued access to services
Annual budget: $1.5 million
Funding source: **Public:** Federal: 80%; State: 20%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Therapy for sexual/domestic abuse		Children of survivors group
	Self-help group (AA/NA)		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 7/12/96

Domestic Abuse Family Shelter

Address: P.O. Box 273
Laurel, MS 39441
Phone: (601) 428-1707
Contact name: Becky Sims, Director
Parent agency: Same as program
Primary problem addressed: Domestic violence
Year began: 1984
Capacity: 20 people total
Setting: Group house
Average length of stay: 2 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $223,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 57%; State: 9%; Local: 34%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services		Separate assessment
	Health education and nutrition		Child health services
	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
	Life skills		
	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
x	Batterers' program		

As of 7/8/96

Domestic Violence Intervention Services, Inc.

Address: 1419 East 15th Street
Tulsa, OK 74120
Phone: (918) 585-3163
Contact name: Felicia Collins Correia, Executive Director
Parent agency: Same as program
Primary problem addressed: Domestic violence
Year began: 1976
Capacity: 22 families
Setting: Group house
Average length of stay: 1 month
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $1.4 million *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 5%; State: 20%; Local: 33%; **Private:** 42%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition		Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
	Self-esteem building/self-awareness		Teen support group
	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
x	Batterers' program		

As of 2/27/96

Exodus

Address: 1500 Kay Street
Compton, CA 90220
Phone: (310) 668-8311
Contact name: Kathryn Icenhower, Director of Administration
Parent agency: SHIELDS for Families, Inc.
Primary problem addressed: Substance abuse
Year began: 1994
Capacity: 50 families
Setting: Individual apartments
Average length of stay: 12–24 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $1.2 million *(excluding transitional housing costs)*
Funding source: Public: Federal: 100%; State: 0%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 10/22/96

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Families in Transition

Address: 3180 Biscayne Boulevard
Miami, FL 33137
Phone: (800) 443-3784
Contact name: Ken Christiansen, Director of Research and Evaluation
Parent agency: The Village
Primary problem addressed: Substance abuse
Year began: 1992
Capacity: 20 families
Setting: Individual apartments
Average length of stay: 10 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $1 million
Funding source: **Public:** Federal: 88%; State: 10%; Local: 2%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 9/18/96

Family Sunshine Center

Address: P.O. Box 4774
Montgomery, AL 36103
Phone: (334) 206-2100
Contact name: Tricia McClellan, Assistant Director
Parent agency: Montgomery Area Family Violence Program, Inc.
Primary problem addressed: Domestic violence
Year began: 1981
Capacity: 12 families
Setting: Group house
Average length of stay: 3–4 months
Aftercare: Periodic phone checks; regular follow-up with an aftercare worker
Annual budget: $380,347
Funding source: Public: Federal: 70%; State: 15%; Local: 15%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition		Child health services
	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
x	Batterers' program		

As of 3/14/96

First Step Home

Address: 2118 Saint Michael Street
Cincinnati, OH 45204
Phone: (513) 921-7324
Contact name: Annie Plummer, Executive Director
Parent agency: First Step Home, Inc.
Primary problem addressed: Substance abuse
Year began: 1990
Capacity: 12 families
Setting: Group house
Average length of stay: 8 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $586,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 47%; State: 8%; Local: 4%; **Private:** 41%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 5/7/96

Flint Odyssey House, Inc.

Address: 1225 Martin Luther King, Jr. Boulevard
Flint, MI 48503
Phone: (810) 238-3801
Contact name: Linda Orgain, Administrative Director
Parent agency: Same as program
Primary problem addressed: Substance abuse
Year began: 1990
Capacity: 20 families
Setting: Group house
Average length of stay: 12 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $850,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 57%; State: 33%; Local: 0%; **Private:** 10%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 1/18/96

Flowering Tree

Address: P.O. Box 1992
Pine Ridge, SD 57770
Phone: (605) 867-5904
Contact name: Alma Brewer, Social Worker
Parent agency: The Oglala Sioux
Primary problem addressed: Substance abuse
Year began: 1992
Capacity: 10 families
Setting: Group house
Average length of stay: 1 year
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $660,000
Funding source: Public: Federal: 100%; State: 0%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		Children
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 6/14/96

G.A.P.P. Family Enrichment Center

Georgia Addiction, Pregnancy and Parenting

Address: 1010 West Peachtree Street
Atlanta, GA 30309

Phone: (404) 894-1382

Contact name: Iris Smith, Principal Investigator

Parent agency: Department of Children & Youth Services

Primary problem addressed: Substance abuse

Year began: 1994

Capacity: 20 families

Setting: Group house

Average length of stay: 6 months

Aftercare: Continued access to services; regular follow-up with an aftercare worker

Annual budget: $1 million

Funding source: **Public:** Federal: 95%; State: 3%; Local: 0%; **Private:** 2%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents
x	Health services
x	Health education and nutrition
	Physical exercise
	Self-defense
x	Life skills
x	Education/job preparation
	Job placement
	Legal advocacy
x	Substance abuse assessment
x	Substance abuse treatment
x	Self-help group (AA/NA)
x	Therapy for sexual/domestic abuse
x	Self-esteem building/self-awareness
x	Interpersonal skills/conflict resolution
	Art therapy

	Services for Other Family Members
	Men's group
x	Family group with nonresidents
	Batterers' program

	Children
x	Separate assessment
x	Child health services
x	After-school program
x	Academic tutoring
	Summer day camp
x	Individual counseling
x	Therapeutic or developmental child care
x	Crisis nursery for respite care
x	Self-esteem building
x	Conflict resolution/socialization
	Children of survivors group
	Personal safety/body rights group
x	Teen support group

	Parent–Child
x	Assessment of parent–child relationship
x	Family therapy
x	Supervised parent–child interaction
x	Organized recreation

As of 8/22/96

Grace Hill

Address: 2600 Hadley Square
St. Louis, MO 63106
Phone: (314) 241-2200
Contact name: Melvia Forniss, Program Director
Parent agency: Grace Hill Neighborhood Services
Primary problem addressed: Substance abuse
Year began: 1994
Capacity: 14 families
Setting: Group house
Average length of stay: 1 year
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $670,000
Funding source: **Public:** Federal: 100%; State: 0%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Therapy for sexual/domestic abuse		Children of survivors group
x	Self-help group (AA/NA)		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 8/8/96

Greentree Shelter

Address: 6301 Greentree Road
Bethesda, MD 20817
Phone: (301) 365-2190
Contact name: Alice Forcier, Assistant Director
Parent agency: Baptist Home for Children and Families
Primary problem addressed: Homelessness
Year began: 1983
Capacity: 15 families
Setting: Group house
Average length of stay: 3 months
Aftercare: Transitional housing
Annual budget: $827,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 2%; State: 76%; Local: 7%; **Private:** 15%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
x	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 10/31/97

Harmony House

Address: 278–282 South Orange Avenue
Newark, NJ 07103
Phone: (201) 623-8555
Contact name: Linwood Oglesby, Administrator
Parent agency: New Community Corporation
Primary problem addressed: Homelessness
Year began: 1989
Capacity: 102 families
Setting: Individual apartments
Average length of stay: 8 months
Aftercare: Periodic phone checks; continued access to services
Annual budget: $2.5 million
Funding source: **Public:** Federal: 50%; State: 45%; Local: 5%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
x	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help groups (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
	Family groups with nonresidents	x	Organized recreation
	Batterers' program		

As of 7/16/96

HerSpace

Address: 5 Thomas Circle NW
Washington, DC 20005
Phone: (202) 667-7001
Contact name: Christel Nichols, Executive Director
Parent agency: House of Ruth
Primary problem addressed: Domestic violence
Year began: 1977
Capacity: 6 families
Setting: Group house
Average length of stay: 2 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $297,000 *(excluding transitional housing costs)*
Funding source: Public: Federal: 39%; State: 0%; Local: 23%; **Private:** 38%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents
	Health services
x	Health education and nutrition
	Physical exercise
	Self-defense
x	Life skills
x	Education/job preparation
x	Job Placement
	Legal advocacy
	Substance abuse assessment
	Substance abuse treatment
	Self-help group (AA/NA)
x	Therapy for sexual/domestic abuse
	Self-esteem building/self-awareness
	Interpersonal skills/conflict resolution
	Art therapy
	Services for Other Family Members
	Men's group
	Family group with nonresidents
	Batterers' program

	Children
x	Separate assessment
	Child health services
x	After-school program
	Academic tutoring
x	Summer day camp
	Individual counseling
x	Therapeutic or developmental child care
	Crisis nursery for respite care
	Self-esteem building
	Conflict resolution/socialization
x	Children of survivors group
	Personal safety/body rights group
	Teen support group
	Parent–Child
x	Assessment of parent–child relationship
	Family therapy
	Supervised parent–child interaction
x	Organized recreation

As of 2/20/97

HerStory House

Address: P.O. Box 313
Rutland, VT 05702
Phone: (802) 775-6788
Contact name: Bonnie Gainer, Director
Parent agency: Rutland County Women's Network & Shelter
Primary problem addressed: Domestic violence
Year began: 1979
Capacity: 8 families
Setting: Group house
Average length of stay: 1 month
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $180,000 *(excluding transitional housing costs)*
Funding source: Public: Federal: 30%; State: 30 %; Local: 20%; **Private:** 20%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services		Separate assessment
	Health education and nutrition		Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
	Life skills		
	Education/job preparation		Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
	Self-esteem building/self-awareness	x	Teen support group
	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents		Organized recreation
x	Batterers' program		

As of 2/29/96

Hutchinson Place

Address: 3439 North Hutchinson Street
Philadelphia, PA 19140
Phone: (215) 223-1006
Contact name: Dorothy Harris, Director
Parent agency: Diagnostic & Rehabilitation Centers
Primary problem addressed: Substance abuse
Year began: 1995
Capacity: 20 families
Setting: Group house
Average length of stay: 9 months
Aftercare: Periodic phone checks
Annual budget: $900,000
Funding source: **Public:** Federal: 50%; State: 40%; Local: 5%; **Private:** 5%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 8/1/96

Integrated Family Treatment Program

Address: 32 West Commerce
San Antonio, TX 78205
Phone: (210) 733-6491
Contact name: Ed Baca, Program Manager
Parent agency: San Antonio Metropolitan Health District
Primary problem addressed: Substance abuse
Year began: 1993
Capacity: 27 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $1.4 million
Funding source: Public: Federal: 42%; State: 58%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 11/27/96

Middle Way House

Address: P.O. Box 95
Bloomington, IN 47402
Phone: (812) 333-7404 (Ext. 204)
Contact name: Toby Strout, Executive Director
Parent agency: Same as program
Primary problem addressed: Domestic violence
Year began: 1971
Capacity: 30 people total
Setting: Group house
Average length of stay: 1 month
Aftercare: Continued access to services; transitional housing
Annual budget: $287,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 53%; State: 16%; Local: 4%; **Private:** 27%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition		Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement		Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 4/11/96

New Empowerment Alternatives

Address: 864 Bellevue Avenue
Trenton, NJ 08618
Phone: (609) 695-1492
Contact name: Susan Gueye, Assistant Executive Director
Parent agency: Union Industrial Home for Children
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1986
Capacity: 12 families
Setting: Group house
Average length of stay: 7 months
Aftercare: Periodic phone checks; transitional housing
Annual budget: $917,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 0%; State: 69%; Local: 0%; **Private:** 31%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job Placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
x	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 6/28/96

A New Life

Address: R.W. Brown Community Center
1701 North 8th Street
Philadelphia, PA 19122
Phone: (215) 763-0900
Contact name: Janet Keyser, Director
Parent agency: Crime Prevention Association of Philadelphia
Primary problem addressed: Substance abuse
Year began: 1991
Capacity: 35 families
Setting: Shared family home (mentor home)
Average length of stay: 6–9 months
Aftercare: Continued access to services; transitional housing
Annual budget: $563,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 0%; State: 0%; Local: 100 %; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 12/12/96

PAR Village

Address: 13800 66th Street North
Largo, FL 33771
Phone: (813) 524-4400
Contact name: Debra Dahl, Director of Children's Services
Parent agency: Operation PAR, Inc.
Primary problem addressed: Substance abuse
Year began: 1990
Capacity: 57 families
Setting: Group house
Average length of stay: 10 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $1.2 million
Funding source: **Public:** Federal: 75%; State: 25%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Therapy for sexual/domestic abuse		Children of survivors group
x	Self-help group (AA/NA)	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 11/3/95

Positive Images

Address: 694 East Grand Boulevard
Detroit, MI 48207
Phone: (313) 921-6050
Contact name: Maisha Kenyatta, Director
Parent agency: Same as above
Primary problem addressed: Substance abuse
Year began: 1987
Capacity: 25 families
Setting: Group house
Average length of stay: 3 months
Aftercare: Continued access to services; transitional housing
Annual budget: $472,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 55%; State: 25%; Local: 10%; **Private:** 10%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 11/5/96

Pregnant & Postpartum Women & Infants Program

Address: 140 North Ashland
Chicago, IL 60607
Phone: (312) 850-0050
Contact name: Jewell Oates, Executive Director
Parent agency: The Women's Treatment Center
Primary problem addressed: Substance abuse
Year began: 1993
Capacity: 16 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Continued access to service; regular follow-up with an aftercare worker; transitional housing
Annual budget: $1 million *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 75%; State: 25%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy	x	Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
x	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 6/12/96

Project BASTA

Address: P.O. Box 18019
Boston, MA 02118
Phone: (617) 521-0100
Contact name: Michelle Drum, Executive Director
Parent agency: Casa Myrna Vasquez
Primary problem addressed: Domestic violence
Year began: 1992
Capacity: 16 families
Setting: Group house
Average length of stay: 14 months
Aftercare: Continued access to services
Annual budget: $675,000
Funding source: Public: Federal: 9%; State: 55%; Local: 17%; **Private:** 19%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job Placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 2/13/97

The Rainbow/The Ark

Address: 475 Broadway, Suite 508
Gary, IN 46402
Phone: (219) 883-4155
Contact name: Gloria Lowe-Walker, Executive Director
Parent agency: Gary Commission on the Status of Women
Primary problem addressed: Domestic violence
Year began: 1976
Capacity: 7 families
Setting: Group house
Average length of stay: 2 weeks
Aftercare: Transitional housing
Annual budget: $250,000 *(excluding transitional housing costs)*
Funding source: Public: Federal: 35%; State: 45%; Local: 15%; **Private:** 5%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		Children
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement		Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
	Self-esteem building/self-awareness		Teen support group
	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 3/1/96

Rainbow House

Address: P.O. Box 29019
Chicago, IL 60629
Phone: (773) 521-5501
Contact name: Geraldine Linas, Executive Director
Parent agency: Same as program
Primary problem addressed: Domestic violence
Year began: 1982
Capacity: 25 families
Setting: Group house
Average length of stay: 2 months
Aftercare: None
Annual budget: $1 million
Funding source: **Public:** Federal: 0%; State: 50%; Local: 0%; **Private:** 50%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 7/10/96

RBHA—Recovering Families Project

Address: 900 East Marshall Street, Suite 160
Richmond, VA 23219
Phone: (804) 780-5876
Contact name: James C. May, Substance Abuse Administrator
Parent agency: Richmond Behavioral Health Authority
Primary problem addressed: Substance abuse
Year began: 1994
Capacity: 14 families
Setting: Group house
Average length of stay: 7 months
Aftercare: Periodic phone checks; continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $950,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 95%; State: 0%; Local: 5%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 8/6/96

Riel House

Address: 1408 West Yakima Avenue
Yakima, WA 98902
Phone: (509) 575-4810
Contact name: April Lane, Program Manager
Parent agency: Triumph Treatment Center
Primary problem addressed: Substance abuse
Year began: 1990
Capacity: 14 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Periodic phone checks; transitional housing
Annual budget: $1.8 million *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 21%; State: 64%; Local: 1%; **Private:** 14%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy	x	Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 11/15/95

Rose McCarthy Family Residence

Address: 882-900 Dumont Avenue
Brooklyn, NY 11207
Phone: (718) 385-5577
Contact name: Ahmad Shabazz, Director
Parent agency: East New York Urban Youth Corps
Primary problem addressed: Homelessness
Year began: 1994
Capacity: 36 families
Setting: Individual apartments
Average length of stay: 9 months
Aftercare: Periodic phone checks
Annual budget: $1.1 million
Funding source: Public: Federal: 0%; State: 50%; Local: 50%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement		Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness	x	Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 3/19/96

St. Martin's House

Address: 116 T Street NE
Washington, DC 20002
Phone: (202) 526-5426
Contact name: Laura Jackson, Program Director
Parent agency: Catholic Charities
Primary problem addressed: Substance Abuse
Year began: 1990
Capacity: 11 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Continued access to services
Annual budget: $355,000
Funding source: Public: Federal: 50%; State: 30%; Local: 0%; **Private:** 20%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition		Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents		Organized recreation
	Batterers' program		

As of 10/29/96

Saratoga, Island, Prospect & Clinton Family Inns

Address: 36 Cooper Square, 6th Floor
New York, NY 10003
Phone: (212) 529-5252
Contact name: Carol Selton, Director of External Affairs
Parent agency: Homes for the Homeless
Primary problem addressed: Homelessness
Year began: 1986
Capacity: 540 families among the four programs
Setting: Individual apartments and group homes
Average length of stay: 7–8 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $15 million (all four programs combined)
Funding source: **Public:** Federal: 48%; State: 24%; Local: 23%; **Private:** 5%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy	x	Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 2/5/96

Seton Home

Address: 1115 Mission Road
San Antonio, TX 78210
Phone: (210) 533-3504
Contact name: Jane Amerson, Director of Social Services
Parent agency: Same as program
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1981
Capacity: 16 families
Setting: Group house
Average length of stay: 10 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $350,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 0%; State: 39%; Local: 0%; **Private:** 61%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 6/25/96

Teen Parenting Services

Address: 87 Spring Street
Portland, ME 04101
Phone: (207) 874-1130 (Ext. 3307)
Contact name: Kathy Chaiklin, Program Director
Parent agency: YWCA of Greater Portland
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1991
Capacity: 7 families
Setting: Individual apartments
Average length of stay: 18 months
Aftercare: Periodic phone checks; continued access to services; regular follow-up with an aftercare worker
Annual budget: $111,000
Funding source: **Public:** Federal: 100%; State: 0%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
x	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 4/4/96

Therapeutic Foster Families

Address: 1279 North Milwaukee Avenue
Chicago, IL 60622
Phone: (773) 278-7200
Contact name: Karl Dennis, Director
Parent agency: Kaleidoscope
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1985
Capacity: 18 families
Setting: Shared family home (foster family home)
Average length of stay: Unknown/until age 21
Aftercare: Periodic phone checks; regular follow-up with an aftercare worker; transitional housing
Annual budget: $335,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 25%; State 70%; Local: 0%; **Private:** 5%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		Children
	Health services		Separate assessment
x	Health education and nutrition		Child health services
	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 11/28/95

Ujima House, Inc.

Address: 4235 West San Juan Avenue
Phoenix, AZ 85019
Phone: (602) 258-1998 (Ext. 915)
Contact name: Valerie Hollmon, President
Parent agency: FIBCO Family Services
Primary problem addressed: Teenage pregnancy and parenting
Year began: 1995
Capacity: 4 families
Setting: Group house
Average length of stay: 1 year
Aftercare: Periodic phone checks
Annual budget: $80,000
Funding source: **Public:** Federal: 0%; State: 0%; Local: 0%; **Private:** 100%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
x	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 3/11/96

Virginia Place

Address: 1156 Horsemans Lane
Lexington, KY 40504
Phone: (606) 258-3198
Contact name: Helen Burg, Executive Director
Parent agency: Same as program
Primary problem addressed: Homelessness
Year began: 1986
Capacity: 55 families
Setting: Individual apartments
Average length of stay: 3 years
Aftercare: Periodic phone checks; regular follow-up with an aftercare worker
Annual budget: $633,000
Funding source: **Public**: Federal: 84%; State: 0%; Local: 5%; **Private:** 11%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
x	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
	Self-help group (AA/NA)		Children of survivors group
	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
			Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 10/26/95

Warren Village

Address: 1323 Gilpin Street
Denver, CO 80218
Phone: (303) 321-2345
Contact name: Susan France, Executive Director
Parent agency: Same as program
Primary problem addressed: Homelessness
Year began: 1974
Capacity: 94 families
Setting: Individual apartments
Average length of stay: 19 months
Aftercare: Continued access to services
Annual budget: $2 million
Funding source: **Public:** Federal: 27%; State: 19%; Local: 1%; **Private:** 53%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services		Separate assessment
	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members		Family therapy
	Men's group	x	Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 10/5/96

Women & Children's Residential Program

Address: P.O. Box 71048
Fairbanks, AK 99707
Phone: (907) 451-8164
Contact name: Victoria Foote, Director, Women & Children Services
Parent agency: Fairbanks Native Association
Primary problem addressed: Substance abuse
Year began: 1994
Capacity: 12 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $775,000 *(excluding transitional housing costs)*
Funding source: Public: Federal: 100%; State: 0%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
	Physical exercise	x	After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 10/9/96

Women Helping Battered Women

Address: P.O. Box 1535
Burlington, VT 05402
Phone: (802) 658-3131
Contact name: Ikey Spear, Children and Youth Services Coordinator
Parent agency: Same as program
Primary problem addressed: Domestic violence
Year began: 1974
Capacity: 6 families
Setting: Group house
Average length of stay: 1 month
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $300,000
Funding source: **Public:** Federal: 28%; State: 22%; Local: 0%; **Private:** 50%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
	Health services	x	Separate assessment
	Health education and nutrition		Child health services
	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
		x	Summer day camp
	Life skills		
	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
x	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment	x	Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
x	Batterers' program		

As of 10/31/95

Women's Residential Services

Address: 1125 North Milwaukee Avenue
Libertyville, IL 60048
Phone: (847) 478-5510
Contact name: Margo Preston, Program Coordinator
Parent agency: Lake County Health Department
Primary problem addressed: Substance abuse
Year began: 1986
Capacity: 16 families
Setting: Group house
Average length of stay: 2–3 months
Aftercare: Periodic phone checks; continued access to services
Annual budget: $899,600
Funding source: Public: Federal: 93.5 %; State: 2%; Local: 4%; **Private:** 0.5%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services		Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise	x	After-school program
	Self-defense		Academic tutoring
		x	Summer day camp
x	Life skills		
	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 5/8/96

Women's Way

Address: 845 22nd Avenue
Honolulu, HI 96916
Phone: (808) 732-2802
Contact name: Claire Woods, Executive Director
Parent agency: Salvation Army Family Treatment Services
Primary problem addressed: Substance abuse
Year began: 1982
Capacity: 21 families
Setting: Group house
Average length of stay: 6 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $1.645 million
Funding source: **Public:** Federal: 35%; State: 58%; Local: 0%; **Private:** 7%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense		Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation		Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment		Self-esteem building
x	Substance abuse treatment		Conflict resolution/socialization
x	Self-help group (AA/NA)		Children of survivors group
x	Therapy for sexual/domestic abuse		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 5/16/96

Woodsong

Address: 1102-H Smith Avenue
Thomasville, GA 31792
Phone: (912) 227-5459
Contact name: Patricia Avé-Lallemant, Project Director
Parent agency: Georgia Pines Community Substance Abuse Services
Primary problem addressed: Substance abuse
Year began: 1994
Capacity: 20 families and 1 family in transitional housing
Setting: Group house
Average length of stay: 9–12 months
Aftercare: Continued access to services; regular follow-up with an aftercare worker; transitional housing
Annual budget: $930,000 *(excluding transitional housing costs)*
Funding source: **Public:** Federal: 85%; State: 0%; Local: 0%; **Private:** 15%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		**Children**
x	Health services	x	Separate assessment
x	Health education and nutrition	x	Child health services
x	Physical exercise		After-school program
	Self-defense	x	Academic tutoring
			Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement	x	Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
x	Substance abuse assessment	x	Self-esteem building
x	Substance abuse treatment	x	Conflict resolution/socialization
x	Self-help group (AA/NA)	x	Children of survivors group
x	Therapy for sexual/domestic abuse	x	Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
x	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group	x	Supervised parent–child interaction
x	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 1/8/96

YWCA Transitional Housing at NIA Terrace

Address: 2055 Hyde Park Road, Number 121
Jacksonville, FL 32210
Phone: (904) 786-6260
Contact name: Al Johnson, Program Director
Parent agency: YWCA of Jacksonville
Primary problem addressed: Homelessness
Year began: 1995
Capacity: 58 families
Setting: Individual apartments
Average length of stay: 1 year
Aftercare: Continued access to services; regular follow-up with an aftercare worker
Annual budget: $480,000
Funding source: **Public:** Federal: 100%; State: 0%; Local: 0%; **Private:** 0%

Primary Services Offered

Generally all family care programs offer individual goal setting and periodic reassessments for the families, ongoing case management, individual counseling, parenting education and support, child care, house meetings, and housing search help. In addition, this program offered the following:

	Parents		Children
	Health services		Separate assessment
	Health education and nutrition		Child health services
	Physical exercise	x	After-school program
x	Self-defense	x	Academic tutoring
		x	Summer day camp
x	Life skills		
x	Education/job preparation	x	Individual counseling
	Job placement		Therapeutic or developmental child care
	Legal advocacy		Crisis nursery for respite care
	Substance abuse assessment		Self-esteem building
	Substance abuse treatment	x	Conflict resolution/socialization
x	Therapy for sexual/domestic abuse	x	Children of survivors group
x	Self-help group (AA/NA)		Personal safety/body rights group
x	Self-esteem building/self-awareness		Teen support group
x	Interpersonal skills/conflict resolution		
	Art therapy		**Parent–Child**
		x	Assessment of parent–child relationship
	Services for Other Family Members	x	Family therapy
	Men's group		Supervised parent–child interaction
	Family group with nonresidents	x	Organized recreation
	Batterers' program		

As of 3/27/96

APPENDIX E

Sources Used in *Healing the Whole Family*

Chapter 4: Family Care and Child Welfare

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Chapter 6: What We Know About the Success of Family Care

Sources of Program Evaluation Data (in addition to CDF's interviews with family care program staff)

ABC—Rosie & Harry's Place. *Association to Benefit Children, Rosie & Harry's Place. A Cumulative Report: November 1993–July 1997. (Draft).* Provides intake data on 81 of the 91 families served during the study period. Includes a family profile and brief discussions of risk factors and strengths of the mothers, family progress, and data on the length of stay as related to success and risk factors. Also includes resident survey results from 27 former residents of the program.

Amity Center for Women and Children. Stevens, S. J., & Arbiter, N. (1995). A Therapeutic Community for Substance-Abusing Pregnant Women and Women with Children: Process and Outcome. *Journal of Psychoactive*

Drugs, 27 (1), 49-56. Describes the program, demographic data, and preliminary outcome data on alcohol and other drug abuse, rearrest, employment, child custody, and involvement in support groups. The sample size includes 161 women who enrolled in the program from November 1990 through September 1994, 57 of whom also took part in the six- and 12-month follow-ups.

Crittenton Hastings House. *TRAC Outcomes, January 1, 1996–March 13, 1996.* Outlines four objectives and related outcomes for the 60 women who were in the program between January 1, 1996, and March 13, 1998. The objectives included reducing repeat pregnancies, advancing education, and improving the health status of both mother and child.

Domestic Violence Intervention Services, Inc. (DVIS). *DVIS: Follow-Up for 1996–1997.* Summarizes a follow-up for 170 men in the DVIS batterers program whose cases had been closed within the last two years. They were divided into three categories according to their level of involvement in counseling sessions. Their success was based on their post-treatment arrests and police incidents.

Exodus. Nunn, Y. J. (1997, Nov.). *Shields for Families: Exodus, Annual Evaluation Report.* Los Angeles: Nunn Consulting, Inc. Presents process and outcome data from the 1996–1997 program year in which 89 clients were served. Describes the program's conceptual framework for providing comprehensive services, the program goals and objectives, demographic data, services provided and evaluation process. Also includes recommendations for ongoing support of the program.

Families in Transition. *The Village Families in Transition Program: Process and Outcome Evaluation Findings.* Includes both quantitative data on outcomes and an assessment of the process and outcome data. Sample size varies with the measure but generally is some subset of the 66 women and 148 children served between FY 1995 and the first two quarters of FY 1996. The outcome data for women and children reported include items such as length of stay, reunification, and children's progress in school.

Flint Odyssey House, Inc. Memorandum on Preliminary Evaluation Findings prepared for CDF by Drs. Rivka Greenberg and Judith Fry McComish, August 28, 1997. Describes characteristics of 30 mothers and 49 children served by the Integrated Children's Grant between spring 1996 and spring 1997. Includes assessment results for both mothers and children and preliminary conclusions about both. Evaluation is ongoing.

G.A.P.P. Family Enrichment Center. Fact Sheet on GAPP Family Enrichment Center. Prepared December 1997. Describes program's goals and services, as well as performance outcomes for parents in the areas of program retention, addiction severity, and psychological status, and for children in the areas of birth outcomes, children's school performance, and participation in aftercare.

Greentree Shelter. Memorandum on Program Evaluations prepared for CDF by Greentree Shelter staff, March 13, 1998. Outlines evaluation methods used, including exit questionnaires, statistical information on client demographics, and questionnaires administered at follow-up visits and reunion gatherings.

Integrated Family Treatment Program. *Maternal and Child Experiences: Integrated Family Treatment Program, San Antonio, Texas, April 1997.* Describes demographic and outcome data on 79 women and 79 children admitted to the program to date. Includes information on birth outcomes, alcohol and drug abuse, and services received.

Middle Way House. Note to CDF from Toby Strout, March 16, 1998. Describes results of families who stayed in the program for more than three weeks.

A New Life. *Preliminary Findings for "A New Life" Program, a Unit of Crime Prevention Association.* Presents brief findings on the women who entered the program between 1996 and 1997, distinguishing among those who participated in mentor home placements and/or transitional housing. Also includes the results from a Client Satisfaction Survey conducted in the summer of 1996.

Project BASTA. Francis, J., & Rosen, J. (1997, Feb.) *Project BASTA: A Transitional Living Program for Pregnant and Postpartum Battered Women and Their Children, Project Closeout Report, Vols. I and II.* Presents an overview of Project BASTA and detailed data on project outcomes, case studies, and post-program interviews. The outcome evaluation includes data on 40 women who stayed in the program at least three months between 1992 and 1996 and had completed assessments. Many of them also were included in the follow-up study of former participants.

Project Together. Beveridge, T., & Saunders, E. *Executive Summary. House of Mercy, Project Together. Program Evaluation: 1992–1997, Final CSAP Report.* Des Moines, IA: House of Mercy. Presents a summary of the program, research questions examined, and results of the program evaluation for women served between 1992–1997. Study looked at 216 women who entered the program and the children who accompanied them. Includes information on outreach efforts, demographic data, parenting, mental health status, exit outcomes, birth outcomes, relapse, developmental progress, and behavioral status of older children.

Prototypes Women's Center. *Evaluation Highlights, 1997.* Summarizes the evaluation findings compiled by the Measurement Group. Include graphs and charts showing program impact on drug abuse, criminal activity, homelessness, and employment. Data were collected from 124 clients between March 1995 and May 1997.

Women & Children's Residential Program. Excerpts from *Women and Children's Residential Program Quarterly Report, April 1997.* Discusses changes, accomplishments, and problems in children's services, as well as outcome and process evaluations for the period July 1 through September 30, 1997. Preliminary findings are based on intake data obtained from 118 women entering the program between August 1994 and August 1997.

Women's Residential Services. *Women's Residential Services Program Evaluation Studies.* Prepared 1990. Summarizes the results of two evaluations of the impact of the program on the women and their children served. Data are reported on parents' stress and self-esteem, parenting, parent–child relationships, and children's behavior.

YWCA Transitional Housing at NIA Terrace. *Annual Progress Report (APR) for Competitive Homeless Assistance Programs, October 27, 1996–October 31, 1997.* Describes data on demographics of and outcomes for 48 families who entered the program during this period, as well as other families already in the program. Outcomes are described in relation to the program's goals, which include permanent housing, increased skills and/or income, and greater self-determination for residents.

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Endnotes for "Is Substance Abuse Treatment Effective?" (See box on pages 74–75. Endnotes correspond to bullets.)

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*The endnotes are those cited by the Legal Action Center in its 1997 report, *Making Welfare Reform Work: Tools for Confronting Alcohol and Drug Problems Among Welfare Recipients.*

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